

12 January 2002

**Help your
customers
stamp out
cigarettes
in 2002**



nicorette[®]
nicotine
Twice as likely to succeed

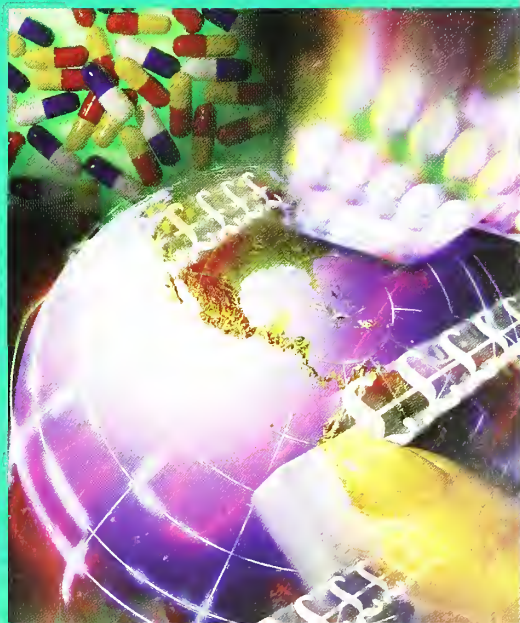
NICORETTE GUM ABBREVIATED PRODUCT INFORMATION: Intended to help smokers who want to give up smoking but who experience difficulty in doing so owing to their dependence on nicotine. Legal Category: GSL. Product Licence Holder: Pharmacia Limited. Date of Preparation: November 2000. Further information is available from Pharmacia Limited, Davy Avenue, Milton Keynes, MK5 8PH, UK. Tel. 01908 661 101.

**Blears fails to
answer PSNC's
pay challenge**

**TV exposé of
Levonelle sale
was 'unfair'**

**Multiples AIM
high with new
lobbying body**

**Finding the
flaws in the
global sum**



There's chance than N

Nicorette has been proven to offer smokers tw

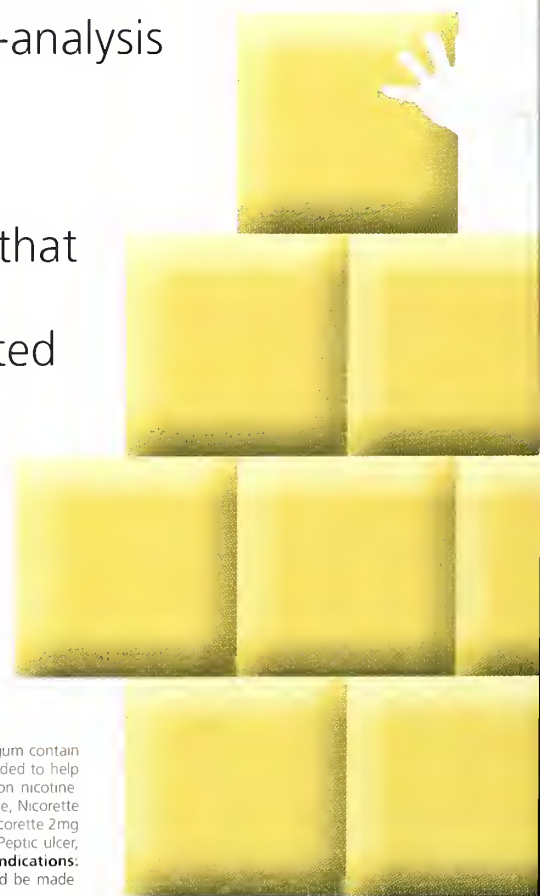
More importantly, there is no more effective form of NRT
than Nicorette Gum.¹

And our claim is based on a meta-analysis
of numerous gum trials.¹

But, the real proof lies in the fact that
over 52m people worldwide have trusted
Nicorette Gum to help them beat
cigarettes one at a time.²

You should know, from September

Nicorette Gum Abbreviated Prescribing Information. Presentation: Nicorette 4mg gum and Nicorette 2mg gum contain 4mg and 2mg of nicotine respectively in a chewing gum base. Original, Citrus or Mint flavour. **Indications:** Intended to help smokers who want to give up smoking but who experience difficulty in doing so owing to their dependence on nicotine. **Dosage & Administration:** Each piece should be chewed slowly for 30 minutes. After 3 months ad libitum dosage, Nicorette gum should be gradually withdrawn. Maximum recommended daily dose: Nicorette 4mg gum: 15 x 4mg pieces. Nicorette 2mg gum: 15 x 2mg pieces. Not to be used by people under age 18 unless recommended by a doctor. **Precautions:** Peptic ulcer, angina pectoris, recent myocardial infarction, serious cardiac arrhythmias, systemic hypertension, gastritis. **Contra-indications:** Pregnancy & Lactation. If the patient cannot give-up smoking without NRT then a risk/benefit assessment should be made.



no better of success corette.

the chance of success over willpower alone.

2000 to September 2001 you've sold twice as much

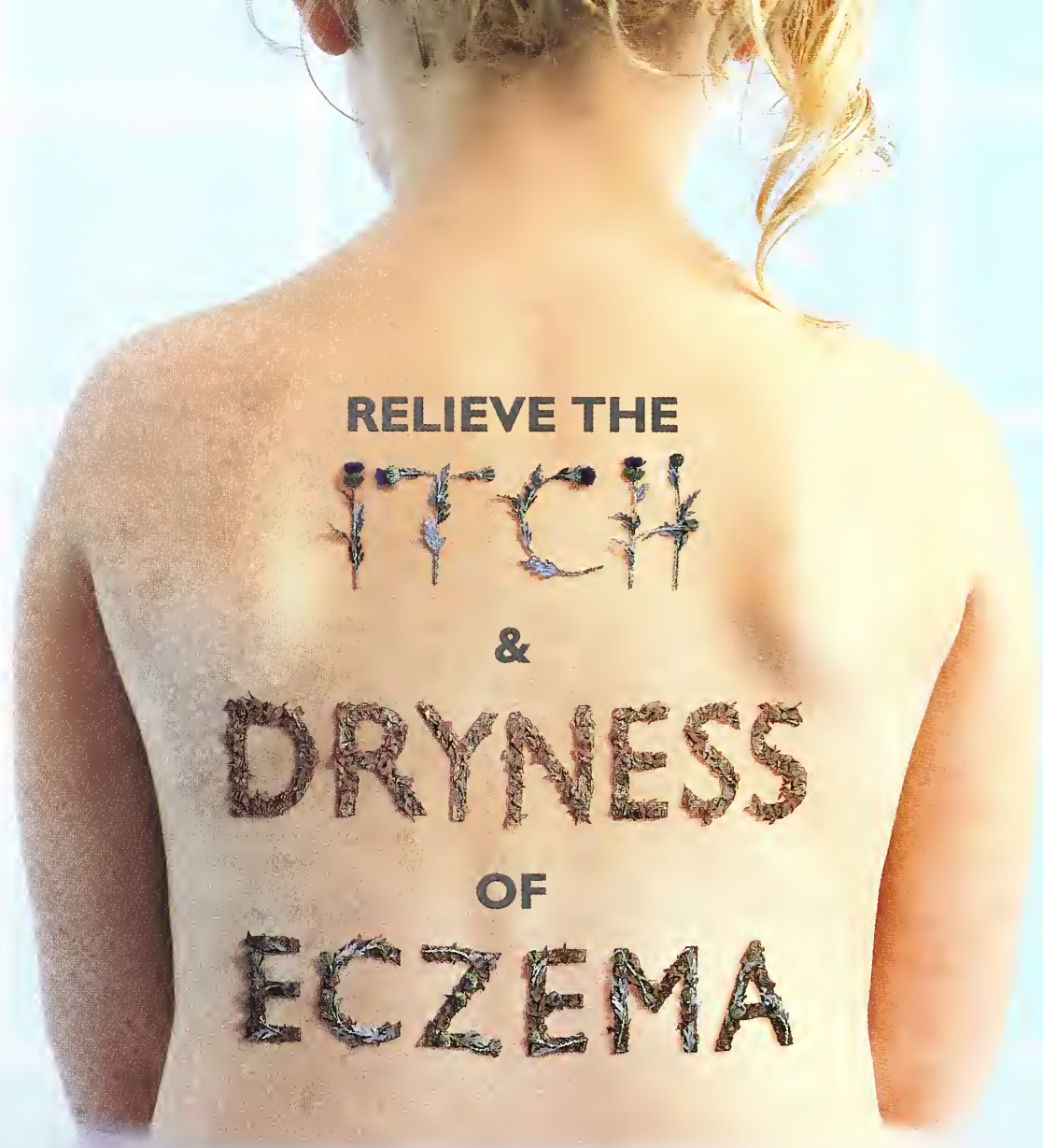
Nicorette Gum as any other NRT.³

With its unsurpassed efficacy, tried
and tested formulations and the widest
choice of flavours, no wonder Nicorette

Gum is still the UK's biggest single selling NRT
format in OTC. Make sure it's yours.

nicorette[®]
nicotine
Twice as likely to succeed

Special Warnings: Rarely dependence. **Adverse Effects:** Gums: Occasional hiccups, indigestion, hyper-salivation, throat irritation, allergy, mouth ulcers. **Pharmaceutical Precautions:** Store below 25°C. **Legal Category:** Nicorette 2mg gum & Nicorette 4mg gum, GSL. **Package Quantities & Cost** (all trade prices correct at time of printing): Gum boxes of 15 pieces, 30 pieces and 105 pieces, in blister strips of 15 pieces. Nicorette 4mg gum (PL00032/0249) (£2.11) (15), (£3.99) (30), (£10.83) (105). Nicorette 2mg gum (PL00032/0248) (£1.71) (15), (£3.25) (30), (£8.89) (105). **PL Holders:** Pharmacia Limited, Davy Avenue, Milton Keynes, MK5 8PH, UK. Tel: 01908 661101. **Date of preparation:** November 2001. **References:** 1. Silagy C et al. Nicotine replacement therapy for smoking cessation (Cochrane Review). In: The Cochrane Library, 2001, Issue 2, 1999. 2. Data on file. 3. IMS Pharmatrend.



RELIEVE THE

ITCH

&

DRYNESS

OF

ECZEMA

WITH FULLY DISPERSING
BALNEUM PLUS BATH OIL

Eczema is both dry and itchy. The itch is the worst aspect of living with eczema.^{1,2}

- Balneum Plus is a dual-action, anti-pruritic emollient bath oil.
- Lauromacrogols in Balneum Plus provide enhanced anti-pruritic activity against itch.
- Soya oil contained in Balneum Plus replaces oils lost by the skin.³
- Fully dispersing Balneum Plus gives all over emollient protection from the moment the patient steps into the bath.

So when you need an emollient bath oil for patients with eczema, remember Balneum Plus Bath Oil. It's ideally suited for the relief of both the dryness and itch of eczema.



Balneum Plus
Soya oil, lauromacrogols

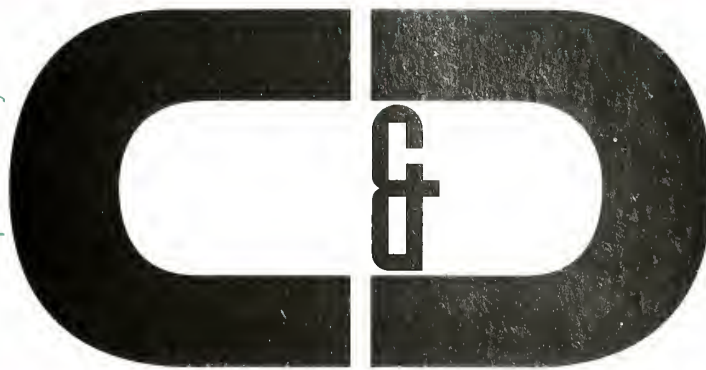
A fully dispersing bath oil for eczema

Prescribing Information **Balneum Plus** An oily liquid for external use containing soya oil B2.95% w/w and mixed lauromacrogols 15% w/w **Uses:** for the treatment of dry skin conditions including those associated with dermatitis and eczema where pruritus is also experienced **Dosage and Administration:** Normally 20ml (1 measure) for a full bath or 2.5ml for a partial bath. If required, this can be increased to 2-3 times this amount. Add to bath water and mix well. Frequency and duration of application depend upon the type and severity of the condition. Adults should use the bath oil frequently,

at least 3 times per week. For babies and infants a 5ml measure for a bath and daily application is recommended. Balneum Plus can also be used in the shower by applying evenly without dilution and rinsing away excess by showering **Contraindications, warnings etc:** Contraindicated in patients hypersensitive to any of the ingredients. Care should be taken to guard against slipping in the bath or shower. Avoid contact of undiluted product with eyes; if this occurs, rinse immediately with water. **Package quantities:** Bottles of 500ml. **MRRP cost:** £13.22 **Legal category:** GSL **Product**

licence number: 00327/0110. **Product licence holder:** Crookes Health Products Ltd, Nottingham, NG2 3AA. **Date of Preparation:** November 2000. **References:** Cork MJ. Complete Emollient Therapy. In: The National Association of Fundholding Pharmacists 1999, April 52. Kopecka B and Borelli S. Praxis 1964; 53(48):1630-32. **CHCSK00197 CROOKES HEALTH**





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DoH defends fraudbuster results

More than 13,000 penalty charge notices for prescription charge evasion have been issued since their introduction in August last year.

The Department of Health has defended the Government's record on fraud in the NHS following a report in the *Sunday Telegraph*, December 30, 2001, which said that the prescription fraud crackdown "had failed".

A spokesman for the DoH said: "In relation to patient prescription fraud, losses have been reduced through preventive action by 41 per cent – a £48 million reduction in losses."

There have also been 83 successful criminal prosecutions since the NHS Counter Fraud unit was set up in 1998, but none of these were patients.

For more information:
www.doh.gov.uk

PRACTICE

Blears confirms annual pay drop

Health minister Hazel Blears has confirmed that pharmacy pay is decreasing in value.

"We forecast that the average value of the basic dispensing fees paid to pharmacy contractors for prescriptions dispensed in 2001-02 will be 93.2 pence, a reduction of 4.4 per cent, compared with 2000-01," she said in a written answer to Mark Todd MP.

And although the global sum for 2001-02 is up 3.7 per cent, remuneration will fall 2.2 per cent in 2001-02 compared to 2000-01, if expressed as the global sum divided by the number of prescription items dispensed.

The DoH forecasts that the number of items dispensed in

2001-02 will be 6 per cent higher than in 2000-01. Further, an overpayment of £8.1m last year is being recovered from this year's payments, she said.

"Taking that overpayment and recovery into account, the actual payment per prescription item for 2001-02 is forecast to be 134.1 pence, a reduction of 4 per cent compared to the actual payment per prescription in 2000-01.

"While we take information and arguments about pharmacy contractors' costs into account when setting remuneration, we have made no assessment of the cost to a pharmacy contractor of supplying each individual prescription."

Ms Blears was also forced to acknowledge that "in spite of increasing training places and introducing recruitment and training initiatives, there have been problems in recruiting pharmacists, particularly over the last year".

However, she added that the increases in pharmacy student intakes – some 27 per cent more students started training in 2000 than in 1993 – point to a medium term growth in the pharmacy workforce.

Workforce modelling undertaken by the DoH suggests there will be a 12 per cent increase in the private and NHS pharmacy workforce between 1998 and 2003, she added.

Boost your business

Make a new year resolution to improve your business skills: register for the *Chemist & Druggist* Pharmacy Business Excellence course sponsored by Crookes Healthcare.

Module 1 was published in our December 1 issue but extra copies can be downloaded from the Crookes website at www.crookes.co.uk. To register for the course, you should complete the form in module 1 and return it to us. If you do not have internet access you can call Mary Prebble on 01732 377269 with your details. You will then be sent a PIN number that gives you access to the telephone marking system.

Each module provides one and a half hour's worth of accredited continuing education. Successful students will have the chance to win £2,500 worth of Crookes Healthcare brands and a complete business makeover in the Crookes Business Person of the Year Award.

Modules will cover stock management, merchandising, marketing and selling skills.

FINANCE

Minister delays pay review reply

Health minister Hazel Blears has so far been unable to justify the procedure used in deciding the pharmacy contractors' remuneration package.

At the beginning of December, the Pharmaceutical Services Negotiating Committee wrote to the minister asking her to review her decision to reduce the dispensing fee to 87.4p. Ms Blears was given a deadline of December 28 to respond to PSNC's "invitation" to accept that the remuneration decision was made on a fundamentally flawed basis (*C&D* December 8 2001, p6).

However, by Monday of this week, PSNC had not had a definitive response. On December 21, PSNC received a letter from the Department acknowledging receipt of the request, but adding that it was working on its answer so would not be able to respond by December 28. The Committee then contacted the Department on January 7, to be told that the person dealing with the matter would not be in the office until January 14.



Hazel Blears: no explanation yet

PSNC chairman Sue Sharpe said this week: "We are anxious for, and will be pressing for, a response."

Meanwhile, three MPs have tabled parliamentary questions to ask the health secretary a series of questions on pharmacist remuneration and the new contract. The oral questions have been tabled for the January 22 session of health questions.

PRACTICE

Medicines pilot gets approval

The Multi-centre Research Ethics Committee (MREC) has approved the community pharmacy medicines management pilot being led by PSNC.

The next stage is for details to go to local research ethics committees in the nine areas involved, so they can comment on any local adjustments needed. Patient recruitment can then go ahead.

MREC approval is necessary for any research involving NHS patients and the use of, or access to, NHS premises or facilities.

Project board chairman Mike King said: "We are delighted that this key element of the project has now received the green light from MREC. It was an extremely thorough and testing process but one which was necessary for a project of this nature."

Project manager John Dixon told *C&D* that MREC's main concern was patient welfare.

"Many of the Committee's queries related to the wording of documents and how they would be understood by patients," he said.



Ibuprofen is officially 40 years old today. Patent no 971,700, which covered ibuprofen and its properties, was filed on January 12 1962. Dr Stewart Adams (far right and, in his younger days, left), who was the principal researcher behind the discovery of ibuprofen 40 years ago, is seen here with his colleagues John Nicholson (centre) and Ray Cobb (right) conducting an erythema assay in their search for anti-inflammatory drugs. Dr Adams, who studied pharmacy at the University of Nottingham, was awarded the OBE in 1987 in recognition of his research culminating in the discovery of ibuprofen

Happy 40th birthday, ibuprofen

The International Ibuprofen Foundation is organising a conference called *Ibuprofen Through the Ages: Past, Present and Future* later this year, to mark the 40th anniversary of ibuprofen's patent.

Leading international scientists will address a range of subjects covering the use and effectiveness of ibuprofen at the conference, which is to be held at the Royal College of Physicians in London on April 15 and 16.

The IIF, which was set up last year, acts as a source of technical, commercial and medical data on the use of ibuprofen. The Foundation aims to develop position papers on major topics relating to the drug, with medical input when appropriate.

A website containing a range of technical data on ibuprofen has also been launched this week by the IIF. Boots Healthcare International, Whitehall Laboratories and Johnson & Johnson MSD support the IIF.

For more information:
www.ibuprofen-foundation.com
Tel: 01372 471607.

PRACTICE

TV portrayal of EHC sale 'unfair'

A pharmacist was unfairly treated in a television exposé on the sale of emergency contraception to under-age girls, according to a ruling by the Broadcasting Standards Commission.

David Taylor complained to the BSC about secretly filmed footage of his Liverpool pharmacy, shown during *Tonight with Trevor Macdonald*, on February 1, 2001. The programme showed a pharmacist employed by Mr Taylor selling the morning after pill to a 15 year old girl, who turned out to be an actress with a hidden camera.

Mr Taylor complained that the pharmacist had questioned the girl thoroughly about her suitability for the pill, but the conversation had been edited to show only how she had lied about her age. The girl had also claimed she had taken EHC before.

Another complaint was that the programme omitted information on the Royal Pharmaceutical Society guidelines on EHC, which do not require pharmacists to obtain proof of age. Mr Taylor

also thought it was unfair to show his pharmacy alongside another in which the pharmacist had prescribed illegally.

In its evidence to the BSC, Granada Television said the programme had concentrated on the ease or difficulty with which an under-age girl could obtain EHC; no other criticism of the pharmacy was stated or implied.

But the Commission upheld the complaint, saying that the programme-maker's decision to concentrate almost exclusively on questions about age gave a misleading impression of the pharmacist's efforts that was unfair to Mr Taylor.

● Schering Health Care says that pharmacy sales of Levonelle (P) accounted for 35 per cent of all EHC requests in 2001. The figure, which excludes supply under patient group directives, reached 40 per cent last November, suggesting that the £20 fee is less of a barrier than expected. The total EHC market, both P and POM, grew by about one-fifth.

UKCPA welcomes Audit report

The United Kingdom Clinical Pharmacy Association has welcomed the Audit Commission's report on medicines management in NHS hospitals – *A Spoonful of Sugar* (C&D, January 5, p16).

In order to tackle the major problem of medication-related issues, pharmacy must be recognised as a clinical profession – although this is not always the case in some hospital trusts, said the UKCPA.

"Lowering the status of pharmacy services has major implications, in terms of addressing the issue of medication-related problems and massive financial wastage to the NHS", it said. The report also raises questions for the profession in the hospital service.

"The main issue which must be addressed is the adoption of national standards for the provision of clinical pharmacy services in NHS hospitals."

For more information:
www.ukcpa.org

This month's Update question paper enclosed

Enclosed in this week's issue is the questionnaire (2220) for the following Pharmacy Update modules carried in December 2001:

- Dental hypersensitivity (1220)
- Creating energy (1221)
- Fats in diabetes (1222)

Pharmacy Update is a distance learning programme accredited by the College of Pharmacy Practice. Previous modules can be accessed on the dotPharmacy website at:

www.dotpharmacy.com.
Further information about enrolling for Pharmacy Update is available from Mary Prebble on 01732 377269. The Pharmacy Update multiple-choice questionnaire and telephone marking service are supported by Genus Pharmaceuticals.



Controlled drugs regs updated

A new set of regulations coming into force on February 1 updates the Misuse of Drugs Regulations 1985.

The main changes in the new set of regulations are as follows:

- The inclusion in Schedule 4 Part I of the new regulations of the 33 benzodiazepines and eight other substances (*see box*). This change will make the drugs subject to import and export controls, and also to controls on their possession when in a medicinal product form. As a result, the unauthorised import, export or possession of any of the substances will become an offence, including their possession without a prescription.
- The addition of 35 phenethylamine derivatives (compounds with properties similar to ecstasy) to the list of Class A drugs specified in Part 1 of Schedule 2 to the Misuse of Drugs Act 1971.
- The 35 phenethylamine derivatives as above are designated under section 7(4) of the 1971 Act which makes production, supply or possession unlawful without a Home Office licence.
- The addition of α -methylphenethylhydroxylamine (also known

as N-hydroxy-amphetamine) to the list of Class B drugs specified in Part II of Sch 2 to the 1971 Act. The compound will also require a licence from the Home Office for possession, supply, manufacture or use.

- The switch to Sch 4 Part II from part 1 of 54 anabolic substances.

A second statutory instrument, amending the Misuse of Drugs (Designation) Order 1986 designates the drugs specified in Part 1 of the Schedule to the Order, which now includes the 35 phenethylamine derivatives as above.

The Home Office points out that, with respect to the tighter controls on the benzodiazepines and eight other substances, practitioners and pharmacists will be authorised by the Regulations to possess the substances when acting in their professional capacity. Patients who have been prescribed any of the 41 substances by a doctor or dentist and who are travelling abroad for no more than one month will not be affected.

The Regulations will not require prescriptions for the 41 substances to be in the doctor's own handwriting.

For more information:

The Misuse of Drugs Act 1971 (Modification) Order 2001: ISBN 0 11 039001 6; SI 3932
The Misuse of Drugs Regulations 2001: ISBN 0 11 039021 0; SI 3998
The Misuse of Drugs (Designation) Order 2001: ISBN 0 11 039020 2; SI 3997.

The 33 benzodiazepines and eight other substances referred to in the new Order are:

alprazolam; bromazepam; brotizolam; camazepam; chlordiazepoxide; clobazam; clonazepam; clorazepic acid; clotiazepam; cloxazolam; delorazepam; diazepam; estazolam; ethyl loflazepate; fludiazepam; flurazepam; halazepam; haloxazolam; ketazolam; lorazepam; lormetazepam; medazepam; midazolam; nimetazepam; nitrazepam; nordazepam; oxazepam; oxazolam; pinazepam; prazepam; tetrazepam; triazolam; aminorex; N-ethyl-amphetamine; fencamfamin; fenproporex; mefenorex; mesocarb; pemoline; pyrovalerone.

CONTRACT

Sharpe questions draft LPS guidance



Sue Sharpe, pictured, is concerned that Government guidance being formulated on local pharmaceutical services (LPS) schemes lacks details of financial incentives for pharmacists.

A draft document, which is on limited circulation for comment, sets out the legal requirements and practical aspects that will need to be followed when drawing up and considering pilot schemes (*C&D* January 5, p5, and this week p18-19). However, Mrs Sharpe, chief executive of the Pharmaceutical Services Negotiating Committee, said on Monday that there were a number of questions the draft guidance raised.

"None of the examples in the schedule [describing various types of LPS contract] answers the question of what or how a contractor can decide whether it is in their interest to go with LPS," she said.

Funding for LPS is to come from the Global Sum but how this would be calculated for LPS has yet to be decided. The idea of LPS is to allow pharmacists to be remunerated for their skill rather than only on items dispensed. However, as every LPS scheme will have dispensing at its core, Mrs Sharpe asked whether contractors would still receive an item fee under LPS.

PSNC's view is that without more detail on payment it's very difficult to say whether contractors should participate or not in LPS, she added. "We have a number of questions we will be raising with the Department to get greater clarity on how LPS will work in real terms."

Questiontime

Do you think a new independent membership organisation should be set up to represent community pharmacists' interests in the UK?

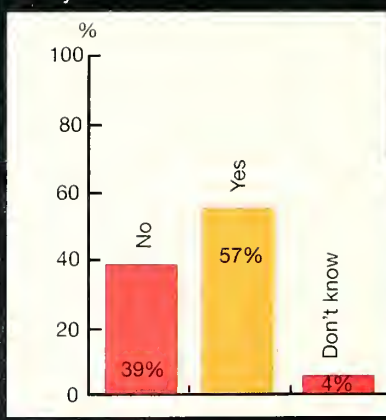
- yes
- no
- don't know

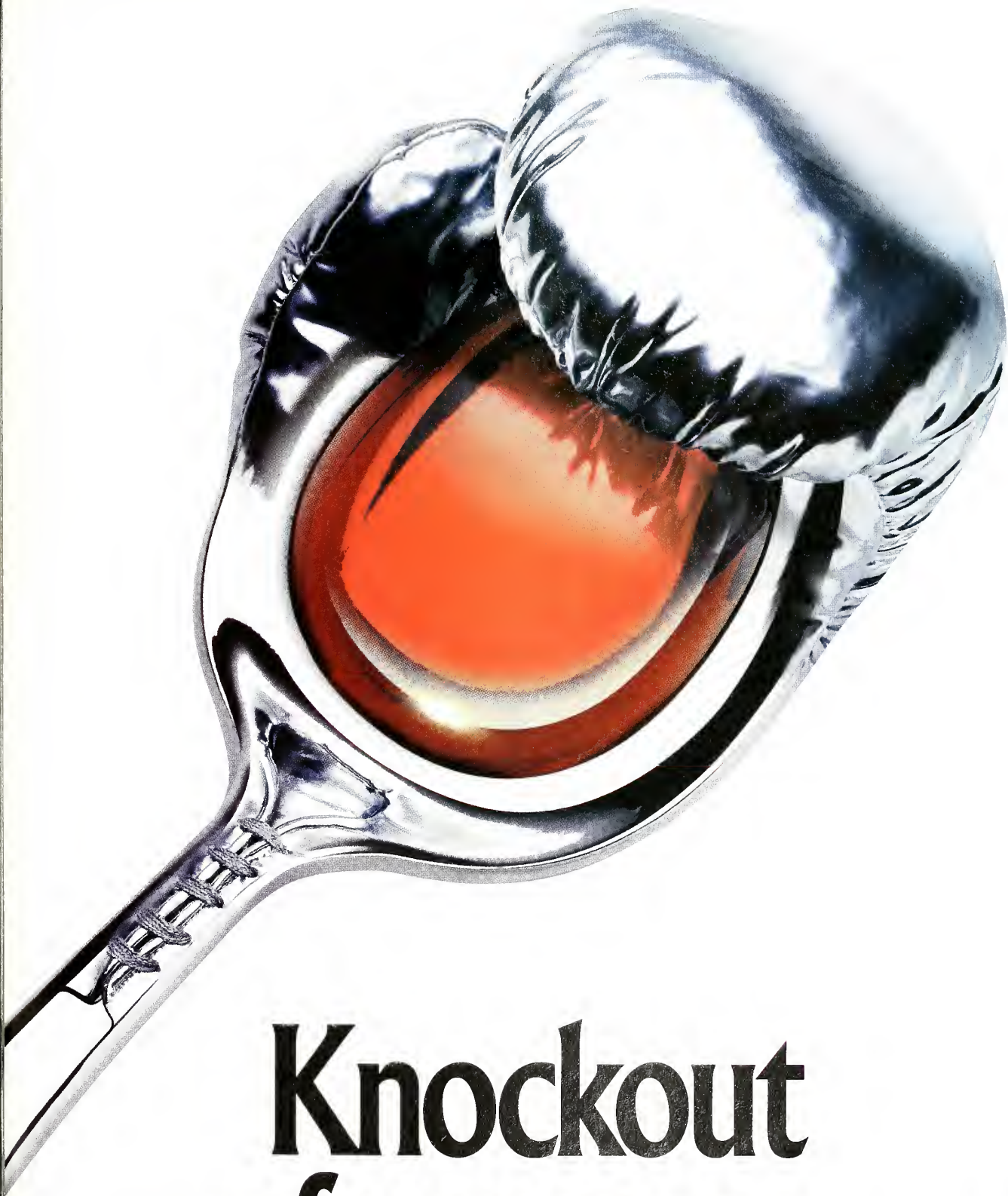
You can record your vote on our website: www.natpharmacy.com. Question Time appears on the home page. Select your answer and then click on the "vote" box. Your answer is automatically collated.

You have until noon on January 15 to cast your vote. We will publish the result in *C&D*, January 19.

Last week we asked you: Do you think the Royal Pharmaceutical Society should be the registration body for pharmacy staff?

What you told us





Knockout performance



The UK's fastest growing cough medicine brand.

Robitussin



*UK's fastest growing cough medicine brand M&P via 2011 (Jan 2001)

Max Dose: 600mg/120ml

Modernisation group announced by Society

The Royal Pharmaceutical Society has announced the membership of its modernisation steering group.

The group will propose methods for modernising the Society's regulatory function and capitalising on its role in professional leadership.

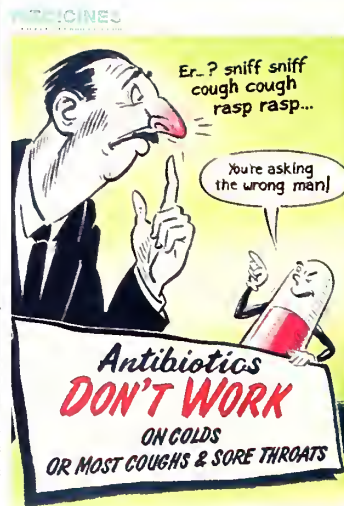
Members of the Society's Council who are part of the group

include Marshall Davies, who will take the chair, Helen Remington, Hemant Patel, Digby Emson, Christine Glover and Dr John Evans.

Other members include Ann Lewis, RPSGB secretary and registrar, Colin Ranshaw and Edward Mallinson of the Society's Welsh and Scottish Executive's respectively, Philip

Green, project director for the modernisation programme, Lord Newton of Braintree, the Society's parliamentary adviser, Robert Bulling, a legal specialist and Professor Peter Noyce, professor of pharmacy practice at Manchester University.

For more information:
www.rpsgb.org.uk



Getting the message on antibiotics

The latest Department of Health public education campaign, which reinforces the message that antibiotics should not be used to treat coughs and colds, includes posters and leaflets which will be sent to pharmacies and GP surgeries and adverts in national newspapers.

The £700,000 campaign, launched on January 3, includes a "non-prescription" pad sent to GPs, on which they can issue written advice to patients as to why antibiotics have not been prescribed and alternative treatments for their symptoms.

Patients are advised to seek treatment from their pharmacy for coughs and sore throats.

For more information:
www.doh.gov.uk

Diabetes training for pharmacists

Pharmacists will be expected to live the life of a patient with diabetes as part of their preparation for a training course developed by the pharmaceutical industry and diabetes specialists.

Improving Glycaemic Control Through Patient Empowerment, a one-day course, aims to improve pharmacists' empathy with diabetic patients as well as their knowledge of the condition. It has been developed by Warwick Diabetes Care and is supported by Roche Diagnostics. An advertisement for the course is featured on the inside back cover of this issue.

For more information:
Tel: 0800 701000.

Moss Pharmacy welcomes new superintendent

Tricia Kennerley has taken over the position of Moss Pharmacy's superintendent pharmacist from Steve Duncan, the pharmacy chain's managing director.

Ms Kennerley will also retain her current position as Moss' NHS services director.

Moss said that incorporating the role of the superintendent into NHS services reflected the increasing emphasis on clinical governance and the quality agenda and on implementing the NHS Plan.

● Tony Foreman, managing director of OTC Direct, a UniChem subsidiary, has been appointed to the UniChem board. OTC Direct was launched in 1997 and specialises in the distribution of generics and parallel imports.



Tricia Kennerley: Moss's new superintendent pharmacist

Pharmology's chief executive officer Sue O'Donnell and clicklocum's managing director Paul Jones sign the agreement



Clicklocum provides locum service for pharmacology website

Clicklocum, the online locum agency owned by private health insurer BUPA, is providing its service for pharmology.com.

A link on pharmology.com's homepage takes registered users through to a framed clicklocum home page, which means that users do not leave the pharmacology site.

The agreement includes an undisclosed revenue-sharing deal between the companies.

A travel information and vaccination service, provided by Netdoctor.co.uk, is also due to go live when pharmacology begins its UK roll-out in the first week of February.

A Dutch version of the site is to be launched in the spring, which will complete pharmacology's launch in countries with a major Alliance UniChem presence.

For more information:
www.pharmology.com



Use the phone to make it

As the role of the community pharmacist develops, pressure on resources becomes more acute. Extemporaneous dispensing is a vital service to offer, but raw material purchasing, stock control, health and safety assessments and dispensing documentation all demand that most vital resource - time.

BCM Specials offer a unique service enabling you to meet your patients needs for the time it takes to make a phone call. With our unrivalled range of formulae, a flexibility to meet your needs and a dedication to get the product to you as quickly as possible, BCM Specials can take the time out of extemporaneous dispensing.

**BCM Specials putting
your patient first.**



www.bcm-specials.co.uk

Acquisition boosts Ransom division

Hertfordshire-based pharmaceutical company William Ransom has boosted its consumer healthcare division with the acquisition of four OTC brands from Roche (*see also Marketwatch, p.28*).

The £6.75 million deal involves all formats of Radian B, Metanium, Valderma and Valpeda, and taking over the lease of Roche's Witham manufacturing plant.

Ransom will contract-manufacture two other Roche products currently produced at the plant, namely Askits and Jaap's.

The acquisition has been financed largely through the placing and open offer of 10.2 million new ordinary shares, which raised £5.12m (£4.4m net of expenses).

Acquisitions are key to the company's four-point strategy for the division, which also includes own-brand development, in-licensing arrangements, and partnerships and collaborations.

"We needed to go away and acquire products in order to finance the other aspects," explained Kevin Robinson, Ransom Consumer Healthcare's general manager.

Ransom said that the current acquisitions were the first major step in its plan to acquire local brands which had the potential for improvement through active brand management and through the introduction of new natural variants.

The company has committed itself to increasing the advertising spend across the portfolio by 150 per cent over the next year.

"Clearly the level of investment in the brands – and the cost of the acquisition itself – signals a significant move by Ransom and establishes a firm foundation on which to grow.

"The natural synergies that exist between William Ransom's traditional manufacturing base and these "new consumer" products places us in a tremendous position to 'buy and build'," said Mr Robinson.

He added that the natural healthcare market in the UK was largely untapped and said a more brand-led approach was needed.

Mr Robinson revealed that Ransom aims to build natural brands on the back of these and future acquisitions.

He added that Ransom was already in talks with major natural healthcare companies in Germany



RANSOM
SINCE 1846

regarding the in-licensing of various brands with a view to launching them in the UK.

The initial focus for Ransom will be Radian B, which it expects to reposition and relaunch in the summer. The company also means to launch new products in order to expand the brands as well as refocusing Radian B's aromatherapy franchise.

The five-year target for the consumer healthcare division is to grow the business from £4m currently to £30m.

Data protection scam uncovered

Trading standards officers are looking into the practices of a company trading under the name of Data Protection Agency Services Limited or Data Collection Enforcement Agency.

Pharmacists are being advised not to use the company's services to register their business under the Data Protection Act 1998.

The Southport-based company had issued a letter stating that the addressee appeared not to be registered with them. It warns that failure to register constitutes a criminal offence and that pharmacists could face a

large fine. It urges contractors to return the enclosed forms immediately.

However, Data Protection Agency charges £111.63 for the registration, compared with only £35 when notifying the data protection commissioner directly.

"They are deliberately making it sound as if they were an agency for the data protection commissioner, which they are not," said Trefor Williams, the National Pharmaceutical Association's head of business support.

He added that the NPA had received more than 20 calls relating

to the company in the space of just one morning.

The data protection commissioner's office said they were aware of the company and a warning posted on its website reiterated that there was no connection between the two.

Pharmacists are advised to ignore any approach made by this organisation and to refer any correspondence they receive to their local Trading Standards Service.

For more information:

www.dpr.gov.uk

Tel: 01625-5457.

SURVEY

No Christmas sales boost

Pharmacists have seen no significant benefits from what was generally described as a bumper Christmas, the Confederation of the British Industry's *Distributive Trades Survey* reveals.

Only 31 per cent of pharmacists reported higher sales in December compared to 65 per cent of retailers overall. Sixty-five per cent of pharmacists on the panel reported stagnating sales and four per cent saw sales drop.

The resulting balance of plus 27 compares with a balance of plus 48 for retail in general.

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Multiples AIM high

Small and medium-sized pharmacy multiples in England and Scotland have formed two organisations to represent their interests because they feel let down by current representative groups.

Fourteen multiples in England, including Day Lewis, Peak Pharmacy and HI Weldrick, are founder members of the Association of Independent Multiple Pharmacies (AIMp).

The Scottish equivalent – a separate organisation, although it will have close links with AIMp – is called the Association of Independent Multiple Pharmacies Scotland (AIMpS).

AIMp's structure closely follows the long-established US equivalent – the National Association of Chain Drug Stores – which has 170 members, representing more than 33,000 stores.

AIMp currently represents 700 pharmacies and shortly expects to gain another 500. Its board includes chairman Peter Cattee (managing director of Peak Pharmacy) and vice chairman Kirit Patel (chief executive of Day Lewis) (*See box for full structure*).

Mr Cattee said the founder members decided to make the move about seven months ago because they felt no-one was lobbying effectively on their behalf. "Large groups have the Company Chemists Association and the National Pharmaceutical Association carries the flag for everyone else. But the NPA is being pulled in different directions because it's dealing with such a large constituency," he said.

But Mr Patel stressed that AIMp would supplement the NPA, Pharmaceutical Services

AIMp board directors: chairman Peter Cattee (managing director of Peak Pharmacy), vice chairman Kirit Patel (chief executive of Day Lewis), general secretary/manufacturers liaison David Vanns (operations director of HI Weldrick), treasurer Yakub Patel (Cohens Chemist), Steven Williams (P Williams Chemist). Full members have 10 to 200 pharmacies. Associate members must have five to nine outlets – they could also include lawyers, accountants and banks.

Membership fee is £500 pa.

Supplier membership fee: £1,000 pa.

Membership fees to fund cost of meetings, which will be held every three months.

Negotiating Committee and other pharmacy organisations – not replace them.

Where some issues could create duplication, such as training, the AIMp will liaise with the NPA.

Meanwhile, AIMp will be talking to the PSNC about possible representation, both on the Committee and on Local Pharmaceutical Committees.

Mr Patel said AIMp members were also disheartened by their perceived lack of input in the NHS Plan consultations. The CCA, he said, had a lot of input with the Government over the Plan. But AIMp members' particular requirements, such as their centralised functions, were ignored by the Plan's policy makers. "Our sector [small/medium sized multiples] has different investment needs to independent pharmacies and very large multiples. We want to influence policy to ensure our sector is not overlooked," he said.

AIMp also wants to avoid duplicating resources while implementing the Plan. Its members, for example, could agree on a plan for clinical governance and circulate it among themselves.

The political lead will come from AIMp's board, while its

members will work closely to share best working practices.

AIMp is confident the Department of Health will consult it, even though the DoH will be liaising indirectly with AIMp members when it talks to the NPA. "It's in the DoH's interests to consult with us because they will eventually be dealing with 30 AIMp members representing 1,500 pharmacies. We can therefore help bring forward the Government agenda," he said.

AIMp has already held one meeting with members to discuss its objectives. It will hold another on January 23 in Leicester, where the guest speakers include Sue Sharpe, chief executive of the PSNC. The Association will then set up a working party to formulate its response to the Office of Fair Trading's control of entry investigation.

After that meeting AIMp will formally approach the Royal Pharmaceutical Society. Mr Patel, who sits on the Society's Council, said it would have to consult AIMp on practice decisions because the multiple members' requirements were different to other Society members.

Manufacturers and wholesalers, meanwhile, can become "supplier members" of AIMp. Mr Patel said these would benefit from a "one-stop communication" to all the pharmacies involved in the new Association. AAI Pharmaceuticals and Astra Zeneca have already signed up. AIMp will approach UniChem shortly.

AIMpS will consist of multiples with 10-50 outlets. Four multiples currently meet that criterion: Glasgow-based AG Bannerman (21 outlets), Blairgowrie-based Davidson's Chemists (21), Lindsay & Gilmour in Edinburgh (21) and Glasgow-based Munro Chemists (22).

The Scottish Association's constitution will be formally ratified in Dumblane on February 20. Douglas Davidson, Davidson's chairman and interim chairman/secretary of AIMpS, said it would shortly approach the Scottish Pharmaceutical General Council to lobby for a seat.

Unlike the English Association, AIMpS will not have associate members/supplier members.

For more information:

E-mail: peter@peakpharmacy.co.uk.

Coming Events

JANUARY 14

East Kent Branch, RPSGB,

Travel Medicine, by Dr Larry Goodyer, at the Howfield Manor Hotel, Chartham Hatch, 7.30 for 8pm.

Nottingham Branch, RPSGB

The New NHS: Structure and Relationships, at the School of Pharmacy, University of Nottingham, 7.30 for 8pm.

JANUARY 15

Moray & Banff Branch, RPSGB

Meal at 7pm followed by curling in Moray Leisure Centre at 9pm.

East Metropolitan Branch, RPSGB

The Pharmacist and the law: staying out of trouble by David Reissner of Charles Russell Solicitors at Wanstead Library, E11, 7.30 for 8pm

JANUARY 16

NICPPET

Microsoft Powerpoint, at The Beeches, Belfast, 9.30am – 5pm.

JANUARY 17

Stirling and Central Scotland Branch, RPSGB

Diabetes: The Patient's Journey in Forth Valley, by Dr S Reith at the Royal Hotel, Bridge of Allan.

NICPPET

Risk Management and CPD, by Dr Terry Maguire and Dr Michael Mawhinney at the NICPET Resource Centre, School of Pharmacy, Belfast, 7pm.



AIMp directors (l-r) Peter Cattee, chairman, Kirit Patel, vice chairman David Vanns, general secretary/manufacturers liaison

Comment

from the Editor



There is one law for the rich, and one for the poor, but for those who fall between, justice can be hard to find. Medium-size pharmacy multiples claim to suffer from the same problem when it comes to representation of their political and business concerns. The Association of Independent Multiple Pharmacies (*see p13*) will, if its ambitions are realised, aim to speak for about 10 per cent of the pharmacy universe. Whether pharmacy needs yet another organisation to add to the multiplicity which already exist is debatable, but AIMp is a fact, and since its members come from probably the most ambitious group of community pharmacy proprietors, it can be expected to punch its weight. It has already set its sights on representation on contractor bodies in England and Scotland, and wants representation on LPCs. The make-up of LPCs has been an issue which everyone has been content to sweep under the table for years, even though most contractors acknowledge it is inequitable. AIMp's ambitions could force this issue into the open.

Small multiples are not the only ones dissatisfied with what their representative bodies stand for. As the RPSGB announces who will sit on its modernisation steering group (*see p10*), debate over whether the Society is a membership group or a regulator (or whether it can continue successfully to be both) is intensifying. With the Society's own journal now claiming it is not a membership organisation, more and more pharmacists are questioning what exactly it does for them. Do pharmacists want to be members of an organisation where half the governing council are lay people? Does the Society want to end up like the General Medical Council with little influence as a professional leader? If ordinary members do not make their voice heard, do not vote in elections and respond to consultations, these are two possible outcomes.

Small multiples are not the only ones asking what their representative bodies stand for...

Your views

Please e-mail your views to chemdrug@cmpinformation.com

IPMI workforce survey 2002

Having agreed with the Institute of Pharmacy Management to conduct our 12th workforce survey, I have this week posted copies of the survey questionnaire to around 150 pharmacy group owners. They have between them around 4,500 pharmacies and employ 7,000 pharmacists. We have asked for the survey to be returned to us by February 22 to allow publication of the results before the end of March.

Many of our regular contributors tell us that they use survey results as "benchmarks" for reviewing salaries of their pharmacists and staff each April. One pharmacy group of four or five outlets has not received a survey form yet but wish to contribute, so I can contact me on 01342 71532 for a copy of the form.

We also value contributions from other community pharmacies

where pharmacists are employed, including single pharmacies, in order to give our survey an industry-wide perspective.

Please note that this year locum agencies will be asked about current locum rates being paid up and down the UK. There has been comment from them that in the past major multiples deliberately play down the rates they are paying most locums they employ.

Confidentiality is paramount to the survey's success. No information given in the survey summary will be directly attributable to an individual company without their agreement.

G Green
Green Pharmacy Consultants
Silver Birches, Cuttinglye
Road, Crawley Down, West
Sussex RH10 4LR

No direct supplies for independents

This week a patient brought into us an FP10 for Innolet Insulin. She had attempted to obtain it from our local Boots branch which was out of stock, but had suggested she try us.

Our wholesaler was out of stock and we phoned the distributor, Farillon, because the patient was down to her last dose. We were told by two staff members that they had a company policy of not supplying independent chemists, but would supply a Boots branch direct.

The customer was unable to understand why we had to send her back to Boots, which received the insulin this morning.

I would emphasise that the Boots staff acted entirely properly, but I would like to know why Farillon has this discriminatory method of distribution, and does it supply the pharmacies of the other two largest national

multiples on a direct basis?

David Sharpe
London NW7

Farillon's managing director, Max Evans, responds:

One of our highest priorities at Farillon is to ensure that patients do not encounter any problems obtaining any of the medical products we distribute. If a retail chemist is unable to obtain a product from their wholesaler, we will always deliver the product directly to them by return. If the chemist has a direct account with us the transaction is simpler because we invoice them directly.

If they do not have a direct account, we require their wholesaler to place an order, but the supply is direct to the pharmacy to minimise delay. We have no policy of differentiating between pharmacies.

I would be happy to speak directly to Mr Sharpe about this.

HOSPITAL REPORT

Pharmacy IT - which way forward?

A recent visit to a colleague in a community pharmacy was most enlightening. He has just updated his computerised labelling and stock control system and had to choose from a bewildering array of software packages. Would that we in hospital had the same luxury.

First we must decide whether the system is for labelling, stock control or both. One of the community systems is probably the best option for labelling only, but it saves time if the system can link to the hospital patient administration system and automatically fill in as many details as possible.

If it is for stock control, do we go for a non-pharmacy package, or a specific pharmacy system? The former gives us access to more systems than the latter.

Most systems specifically for pharmacy allow users to produce charts of drug usage, formulary adherence, stock value etc, but so do other systems if equipped with

Instead of being able to choose the best, you choose the least worst - or the cheapest

appropriate reporting software.

Some pharmacy systems can do item searches on generic or trade name or by BNF classification and the BNF is often included with the package.

However, these systems usually seem to have patches for functions which don't work as expected. Balances seem to be a regular weak point. Imagine a community system that could not properly handle balances!

In comparison to community pharmacy, the hospital market is small and this is reflected in the paucity of options. Instead of being able to choose the best, you choose the least worst - or the cheapest. What a way to run a service!

Contributed by a senior hospital pharmacist

TOPICAL REFLECTIONS

A NICE comment is worth the wait

In an NHS strapped for cash the Health Secretary Alan Milburn not only wants to encourage GPs to refer patients to alternative therapies but is proposing to pay them extra to achieve it (*C&D* January 5, p7).

At the same time he has announced an independent working party to draw up proposals for the statutory regulation of herbal medicine. I have always advocated the rational use of alternative therapies, but I question why GPs should be paid extra to refer their patients to them.

Whenever pharmacists suggest alternatives to current healthcare delivery they are told to make a bid backed up by evidence.

Now, alternative practitioners have an opportunity to prove the value of their therapies, as Alan Milburn has asked the National Institute for Clinical Excellence to evaluate their effectiveness. It is to NICE that the evidence should be presented and it is for NICE to objectively comment. Alan Milburn has muddied the waters of good proposals for the objective use of alternative therapies and the regulation of herbal medicine by suggesting an incentive for GPs.

He should rethink, and leave evaluation and implementation where it belongs. That is with the National Institute for Clinical Excellence which his Government established.

Clinical governance and the new contract

Clinical governance is an area of concern for me so I was grateful for such a clear explanation of its meaning and implication by NPA chief executive, John D'Arcy (*C&D* January 5, p8). I am always trying to improve my quality of care and I am acutely aware of the need for risk management. As Mr D'Arcy says, the CPPE workshop on risk management is a must.

Mr D'Arcy considers that our response to clinical governance participation will influence the eventual shape of the new contract. So do I detect another hidden challenge?

It is reasonable to expect that pharmacists operating a contract that pays for quality care should demonstrate a commitment to achieving

improvements. On the other hand, it is not reasonable to expect those same practitioners to enthusiastically participate without knowing the detail and timetable for our new contract.

Yes, clinical governance is important and is a Government priority but it cannot be delivered while I have to practice under the yoke of the existing contract.

The Health Minister, Hazel Blears, has already nailed her colours firmly to the mast by refusing to pay for any increase in prescription numbers. Likewise I cannot afford any more time for unremunerated Government initiatives.

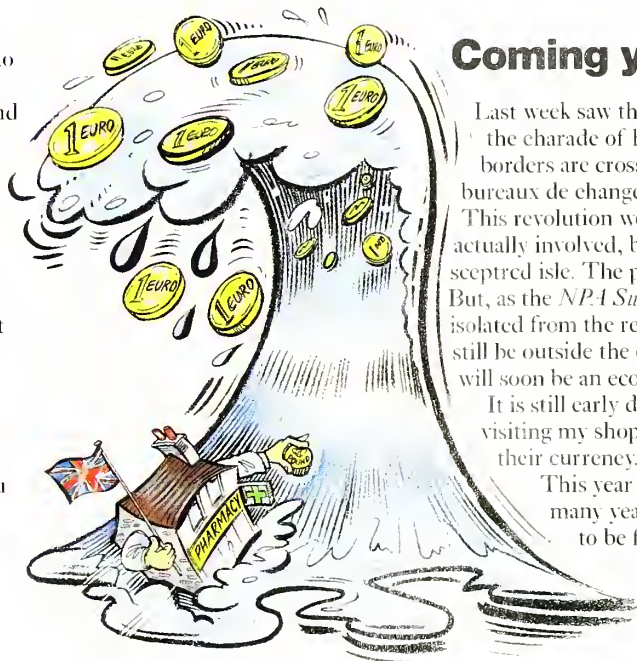
Coming your way - the euro

Last week saw the Europe-wide introduction of the euro. At last the charade of having to change to different currencies as borders are crossed will be removed. The only losers are the bureaux de change.

This revolution would be all the more memorable if I were actually involved, but siege mentality still reigns supreme in this sceptred isle. The pound sterling is not yet yesterday's news. But, as the *NPA Supplement* reminds me, I cannot remain forever isolated from the realities of change. Whereas politically we may still be outside the euro-zone, dual currency trading in our shops will soon be an economic necessity.

It is still early days but I, too, can see that very quickly those visiting my shop from the EU will expect that I will accept their currency.

This year I expect to install a full EPoS system after many years of prevarication. That system will now have to be fully compatible with the inevitability of a UK market where, even if the euro is not the official currency, it will demand parallel acceptability.





Barnsley MP Eric Illsley visited a new Superdrug in the Yorkshire town last week to launch a "Healthy heart and diabetes" assessment service. Mr Illsley was the first person to undergo a complete consultation at the store. Consultations are conducted by a qualified nurse. Tests take about 30 minutes and cost £20. Superdrug has teamed up with Scancare Services Ltd to provide the new assessment service. Mr Illsley is pictured with Mary Wainwright, a member of the Superdrug pharmacy team at the Cheapside, Barnsley store

Portadown pharmacist never to practise again

A Portadown pharmacist who had repeatedly tried to sell his business has given a public undertaking never to practice as a pharmacist again after appearing before the Statutory Committee of the Pharmaceutical Society of Northern Ireland.

Thomas Lee, who owned the pharmacy at 7 Church Street, Portadown, Co Armagh, appeared before the Committee on December 22, 2001 to answer complaints about the state of his premises made to the Society by the Department of Health's pharmacy inspector, Dr Michael Mawhinney. Mr Lee has since sold the business.

Dr Mawhinney inspected the pharmacy on July 6, accompanied by a professional standards inspector from the Royal Pharmaceutical Society, said Miss Horan, for the PSNI. They found that practices and premises fell well below the expected standards.

The inspectors found that the shelves and dispensing benches contained a large number of out-of-date and unlabelled medicines. Some appeared to be patients' returned items.

Guidelines on the safe storage of medical oxygen were breached. Full and empty cylinders were not separated, they were stored next to domestic gas cylinders, and there were no warning signs in place.

A 100 tablet pack of Valium 10mg tablets was found lying on the floor in the storage area in breach of the Misuse of Drugs Act 1973. The fridge

thermometer did not work, and the temperature was last recorded over a year ago, said Miss Horan.

Mr Lee was not on the premises when Dr Mawhinney arrived on July 6, nor was he there when the inspector arrived for a further inspection visit on August 22, 2001.

Although standards in the dispensary had by then improved – the heavily contaminated tablet counter had been cleaned – the pharmacy still fell below acceptable standards, said Miss Horan. The rear dispensing area where nostrums were prepared was still dirty and disorganised, she said.

Dr Mawhinney had found 31 out-of-date medicines on the shelves. Caustic soda and bleach was stored among human medicines, and there were a number of unmarked bottles in the rear dispensary.

Mr Lee pleaded guilty and admitted the substance of the allegations. Miss Simpson, for Mr Lee, said he was greatly upset by the situation and wished to stop practising as a pharmacist.

Reading a prepared statement, Mr Lee accepted total responsibility for all the findings. He was weeks away from his 73rd birthday and age had taken its toll and reduced his commitment, he said.

He had on several occasions tried to sell his business, but without success. There was some civil unrest in Portadown – at certain times of the year there was

an exodus from the town. The Health Board had to provide him with a letter to help ensure his safe passage to work. Dr Mawhinney had visited on July 6. The Drumcree march was on July 8 and the pharmacy was under severe pressure and understaffed.

Various testimonials were presented. Miss Simpson said Mr Lee was not underplaying the significance of the charges, but asked the Committee to weigh up 50 years of service when considering its decision. Mr Lee should be allowed to retire with dignity.

In summing up, Mr Ferris said the Committee took a serious view of the evidence regarding lapses in practice and breaches of the Code of Ethics.

"Collectively or singularly the charges justify striking Mr Lee's name from the Register. On the other hand, having heard that Mr Lee has given over 40 years of practice and was a past president of the UCA, and seeing an impressive array of references, this is a man who has conducted himself well.

"It was all the sadder that his practice came to this. We have heard he has sold his business and will not practice from January 2," he said.

Mr Ferris went on to say that the Committee would adjourn the hearing to June 6 and permit Mr Lee's name to remain on the Register until May 31 provided he did not seek re-entry to the register after that. It was likely that no further steps would be taken.

PEOPLE

Nominations needed for CPP election

The College of Pharmacy Practice is inviting nominations for three governors and one associate representative for its forthcoming elections.

Nominations must be received by noon on February 4 and the results will be announced at the AGM on May 2.

Dr Claire Anderson, Charles Butler and David Morgan are the three outgoing governors, having completed their three-year period of office.

Mel Smith is the retiring associate representative and is eligible for re-election.

For more information:

E-mail: info@collpharm.org

Tel: 024 7669 2400.

PRACTICE

Geriatric medicines book issued

The Pharmaceutical Press has published *Medicines in the Elderly – an introduction to therapeutics in the elderly*.

The book discusses drug therapies for diseases affecting the major body systems, anti-infective therapy, altered drug responses, palliative care, compliance, concordance and polypharmacy and research in elderly patients.

Many medicines-related aspects of care in the elderly are highlighted in *The National Service Framework for Older People* and its supplement *Medicines for Older People*.

For more information:

Price: £29.95

ISBN: 085369446X,

Pharmaceutical Press,

Tel: 020 7735 9141.

BPSA conference

The British Pharmaceutical Students' Association's 60th annual conference will take place on March 22-30 in Glasgow. For more information contact conference@bpsa.com

Product Information Nurofen For

Children: Suspension containing ibuprofen 100 mg/5 ml. **Prescription**

and OTC: For the fast and effective reduction of fever, including post immunisation pyrexia and the fast and effective relief of mild to moderate pain, such as sore throat, teething pain, toothache, earache, headache, minor aches and sprains. **Dosage:** For pain and fever: The daily dosage of Nurofen For Children is 20-30 mg/kg

bodyweight in divided doses. This can be achieved as follows: Infants 6-12 months: One 2.5 ml spoonful may be taken 3 to 4 times in 24 hours. Children 1-3 years: One 5 ml spoonful may be taken 3 times in 24 hours. Children 4-6 years: 7.5 ml (5 ml + 2.5 ml spoonful) may be taken 3 times in 24 hours.

Children 7-9 years: Two 5 ml spoonfuls may be taken 3 times in 24 hours.

Children 10-12 years: Three 5 ml spoonfuls may be taken 3 times in 24 hours. Not suitable for children under 6 months of age unless advised by your doctor. For Juvenile Rheumatoid Arthritis: The usual daily dosage is 30 to

40 mg/kg/day in three to four divided doses. For post immunisation pyrexia: One 2.5 ml spoonful followed by one further 2.5 ml spoonful 6 hours later if necessary. No more than two 2.5 ml spoonfuls in 24 hours. If the fever is not reduced, consult your doctor. For oral administration. For short term use only.

Contraindications: Hypersensitivity to any of the constituents. Patients with a history of, or existing peptic ulceration.

Patients with a history of asthma, rhinitis or urticaria associated with aspirin or other non-steroidal anti-inflammatory drugs. **Precautions and Warnings:**

If symptoms persist for more than 3 days, consult your doctor. Do not exceed the stated dose. Caution is required in patients with renal, cardiac or hepatic impairment. Asthma sufferers, anyone allergic to aspirin, receiving any other regular treatment and pregnant women should consult their doctor before taking Nurofen For Children.

Nurofen For Children is not suitable for patients who have a stomach ulcer or other stomach disorder. Not recommended for children under 6 months unless advised by a doctor. **Side**

effects: Hypersensitivity reactions have been reported following treatment with ibuprofen. These may consist of

(a) non-specific allergic reaction and anaphylaxis, (b) respiratory tract reactivity comprising of asthma,

aggravated asthma, bronchospasm or dyspnoea, or (c) assorted skin disorders, including rashes of various types,

pruritis, urticaria, purpura, angioedema and, more rarely, bullous dermatoses (including epidermal necrolysis and erythema multiforme). Side effects are

are but may include abdominal pain, nausea, dyspepsia and gastrointestinal bleeding and peptic ulceration. Also

very rarely thrombocytopenia has been reported. Bronchospasm may be precipitated in patients with a history of

aspirin sensitive asthma. **Product**

licence Number: PL 00327/0085.

licence Holder: Crookes Healthcare Limited, Nottingham, NG2 3AA. **Legal**

category: P. **Price:** Pack size 100ml: £3.35 Pack size 150 ml: £4.59. **Date**

of preparation: June 2001. NU281.

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from 6 months



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Local pharmaceutical services could revolutionise the provision of pharmacy care and how it is contracted within the NHS. So what are the Department of Health's current thoughts on LPS?

There's many an LPS...

Last September Health Minister Hazel Blears said the new pharmacy contract would be negotiated once local pharmaceutical service (LPS) pilots were underway.

This was not quite what had been promised by her predecessor Lord Hunt, as he had told a meeting of the All-Party Pharmacy Group that negotiations were expected to start early in 2001. Ms Blears was now suggesting that discussions would be put back to late 2002.

But Ms Blears did endorse the view that LPS would be a significant part of the future of pharmacy provision in England. And other than working with the broad parameters set out in the

Basically, LPS is one way to take forward the aims and pledges of the *NHS Plan* and *Pharmacy in the Future* programme. These include reshaping services around patients, making better use of the skills and dedication of NHS staff, responding to the changing environment while improving quality and enhancing public confidence in the pharmacy profession.

Following on from this, the DoH is now finalising its basic guidance for setting the ball rolling later this spring. Just before Christmas, Theresa Prendergast, the LPS implementation manager at the Department's pharmacy and prescription branch sent out draft



care organisations or health authorities to negotiate.

Much of the formal structuring comes from the *Health and Social Care Act 2001 (H&SC Act 01)*, but other aspects have been indicated by the health minister, chief pharmaceutical officer and others in presentations to pharmacists over the past few months.

Ms Prendergast says the LPS pilots will provide a flexible alternative to the existing national contract. This should allow the development of "innovative ways of contracting for core pharmacy services like dispensing" and will "offer community pharmacists and pharmacy owners an opportunity to work within a contract that they themselves help design".

"Pilots will tackle local health priorities and the nature and scale of the pilots will vary as much as the issues they address," she says.

Note, though, that LPS will be voluntary; any pharmacist contracting for services under the current contract does not have to participate under the new LPS scheme. Instead, they would retain the current contract format as set out under Part II of the *NHS Act 1977*.

So what will LPS entail? Above all, dispensing will remain at the heart of all pharmacy services, whether with the current contract format or with the LPS pilot schemes. But LPS will also allow

other pharmaceutical and non-pharmaceutical services, including "activities not traditionally associated with pharmacies".

Ms Prendergast's circular points out that the new *H&SC Act 01* encompasses several principles:

- new approaches will be piloted
- pilots may include arrangements for the provision of training and education
- pilots may not be combined with personal medical services (PMS) or personal dental services (PDS) in the same contract, although a separate LPS contract may be held alongside either
- pilots must include dispensing services, whether to general or particular groups of patients
- pilots will be evaluated
- each pilot must be reviewed at least once within the first three years of implementation
- pilots must be approved centrally.

On this final point, Ms Prendergast says that the *NHS Reform and Health Care Professions Bill* includes the power to delegate. However, the Department has no immediate plans for this to happen.

Dispensing doctors are excluded from providing LPS, and as PCTs will be taking over responsibility for managing LPS pilots, they will not actually be providers of LPS. However, bodies such as NHS trusts, bodie

"LPS will offer pharmacists a chance to work within a contract they help design"

Health and Social Care Act 2001, applicants for providing LPS must first design their services in any number of ways. The Department did not want to be prescriptive, she said, it just wanted to see what schemes were proposed. It would be "inundated with ideas for new ways of working" she anticipated at the Glasgow BPC. (*JCD September '99, 2001, p6*).

documents to three interested groups, setting out the Department's current, but not definitive, thinking on how LPS should be implemented.

The draft document does not contain too much that is new, but it does consolidate what has been said already, as well as giving a clearer idea of how much the Department will direct LPS and how much will be left to primary

“LPS will also include activities not traditionally associated with pharmacies”

corporate or “other individuals” may also apply to supply LPS.

While community pharmacists will be actively encouraged to propose schemes, if there are no proposals for an area the PCT or health authority would like tackled, then they would be able to draw up a proposal which would then be put out to tender.

The draft guidance on LPS points out that while HAs or PCTs are expected to consider all outline proposals for LPS or PMS schemes, there is no requirement for them to put forward for further development and approval all outline LPS proposals which they receive, unlike PMS.

Instead, HAs or PCTs will need to make sure that it is clear from the outset what selection criteria will be used. “It will be much easier for HAs/PCTs to justify decisions not to take proposals forward if they can show that they have been assessed against previously agreed criteria,” says the draft guidance. This should help reduce the likelihood of accusations of bias.

PCTs will have to consult with other PCTs if a proposed scheme is likely to affect services in another PCT.

Further, it is proposed that HAs or PCTs will have the power to designate neighbourhoods, remises and the description of remises for the purposes of LPS. Designation will allow HAs/PCTs to defer consideration

of applications for the provision of Part II services under existing terms of entry for a neighbourhood, an area or premises which is being considered for LPS. However, this will require regulation.

Pharmacy contractors who leave the current “PhS contract” and provide LPS from existing or nearby premises will be able to revert to PhS status when the LPS contract ends. “This is meant as a re-admission rather than an opportunity to become a PhS contractor by a route which circumvents the current rules for becoming a PhS contractor,” says the guidance. How contractors may revert will be established before the contract is signed.

If all this seems to centre on what the pharmacist can expect in LPS, remember that this is ultimately for the benefit of the patient. “From a patient’s perspective, LPS pilots will combine better quality healthcare with ease of access,” says Ms Prendergast. “They will build on existing relationships and patients will see the benefits of LPS in services which have been designed with their needs in mind.”

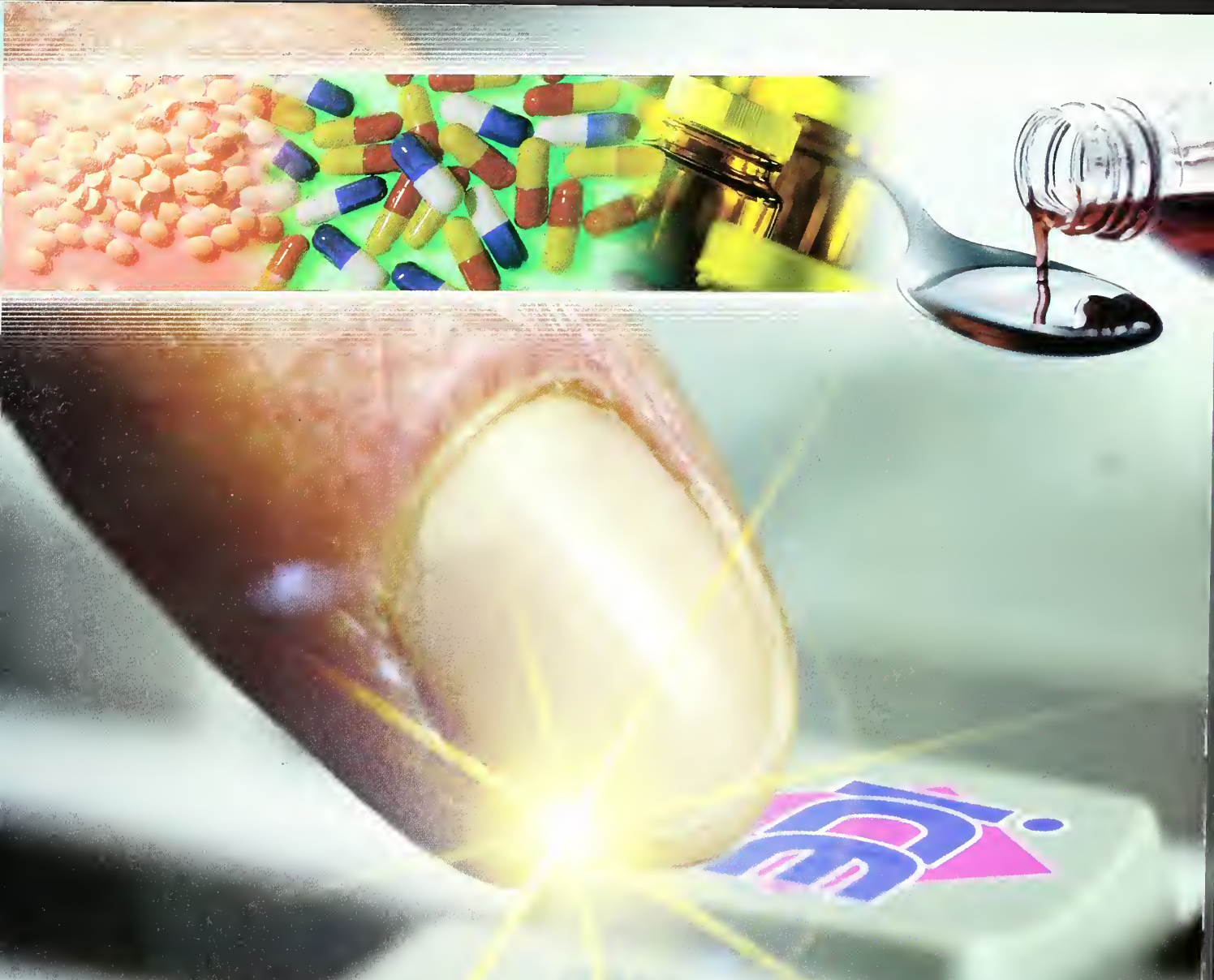
The DoH is still drawing up its guidance for LPS. What has been discussed here is the contents of a circular sent to members of the Medicines Management Advisory Group, the LPS Reference Group and PharmNet. They have until January 30.

LPS provider arrangements

In all cases the services provided under LPS must respond to local priorities and/or needs. Contracts will be negotiated individually and in the examples given below it is assumed that the services proposed have been agreed by the HA/PCT.

- Current pharmacy contractor wants to move away from current PhS contract to a contract which will allow time to be devoted to the more clinical aspect of the services delivered and where remuneration is not dependant on the number of scripts dispensed. May or may not provide other services which had not been available at the particular pharmacy to date.
- The pharmacy contractor wants to provide not just dispensing and traditional pharmacy services in his region, but other services too. For example, treating diabetic patients and providing other services that could include chiropody, health promotion and diagnostic testing. The contractor may wish to bring together other health professionals to help deliver such services.
- Pharmacy contractor wants to provide dispensing and pharmacy services to the general population but also wants to develop specific services for specific groups, e.g. services for drug misusers, which will include dispensing methadone and other agents, and an enhanced role of supervision, administration, counselling and advice.
- Pharmacy contractor associated with a local walk-in centre wishes to change hours of services to correspond with walk-in-centre opening hours. Intention is that the pharmacy will be operated as part of the overall walk-in centre team and will also act as a triage point.
- Current pharmacist contractor wishes to retain contractor status, but wishes to provide LPS for a particular patient group/area as part of a pilot scheme for which the HA/PCT already has “preliminary approval” and has invited applications from prospective providers. In this case the pharmacy contractor, if successful, will provide LPS services from a premises other than that from which “PhS contractor services are provided. We have in mind that only rarely is it likely to be possible for LPS and PhS services to be provided from the same premises and then only if the two are clearly distinguishable”.
- Pharmacy contractors who may wish to retain their PhS contractor status, but wish to join with other pharmacy contractors (perhaps in their locality) to provide a dispensing and general pharmacy and/or other services, under LPS, to the general population or a specific group in a designated area or premises. In this case pharmacy contractors who favour this arrangement must form themselves into a legal entity, and the LPS contract will be between the HA/PCT and the legal entity.
- As in the point above, but parties to the agreement include PhS contractors with other health professionals, or indeed non-health professionals who have formed a legal entity.
Again, the LPS contract will be between the HA/PCT and the legal entity.
- NHS Trusts Although PCTs (and that includes PCT-based Care Trusts) cannot be providers of LPS, NHS Trusts can. In order to be providers of LPS, such Trusts would have to be in a position to comply with the requirements of LPS, including the provision of dispensing services (NHS Trust pharmacy would have to be registered as a retail pharmacy business.)
- Bodies corporate Bodies corporate, whether or not currently conducting a lawful retail pharmacy business, may propose and contract to provide services under LPS pilots in the same way as others.

Ms Prendergast can be contacted at the Pharmacy and Prescriptions Branch, Room 158, Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS.



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For further details contact Mary Prebble on 01732 377269.

Dr Alex Williams, a GP at St Thomas's Health Centre in Exeter, explains how pharmacists can help those for whom unhappiness is more than post-Christmas, dreary winter blues

Clinical depression



- To be aware of symptoms suggesting clinical depression
- To understand the rationale behind drugs used in depression
- To know what to advise patients taking these drugs
- To understand how to encourage compliance
- To be aware of what additional interventions are helpful

Forty per cent of the population have feelings of depressed mood such as unhappiness and disappointment. About one fifth of people seen in primary care have depressive symptoms. The diagnosis is missed in around half these patients. At least one quarter of patients with marked depression do not consult their GP.

So why is depression missed in so many patients? Some factors are that patients may not recognise they are ill, there is a stigma attached to psychiatric illness or medication, and patients do not know that depression can be treated easily. The doctor may not recognise depressive symptoms and may misdiagnose physical illnesses, attributing depressive symptoms to understandable reactions to adverse life events.

Symptoms

Some factors that may raise the suspicion of depression are patients presenting with unexplained physical symptoms, frequent attenders who may also have a thick file, a concurrent physical illness or disability and a family history of depression. I always suspect depression when a consultation seems to be dysfunctional and there is no obvious reason. When I get these feelings I restructure the consultation and enquire closely about symptoms of depression.

Depressive symptoms have been classified by both the American Psychiatric Association Diagnostic



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and Statistical Manual (DSM III) and the International Classification of Diseases (ICD). These suggest that depression is present when four or five core symptoms have been present for at least two weeks. The core symptoms are:

- depressed mood
- loss of interest or pleasure
- loss of energy or fatigue
- concentration difficulties
- appetite disturbance
- sleep disturbance
- agitation or retardation
- sense of worthlessness or self-blame
- thoughts of self-harm or suicide.

Other symptoms may include reduced libido, reduced self-confidence, or physical symptoms.

When making a diagnosis and deciding on the management it is also important to assess other underlying problems such as excess alcohol intake, drug misuse, socio-economic environment, relationships and support, family history or co-existing anxiety.

Depression is twice as prevalent in women as it is in men. Depression may also present with physical symptoms, co-existing with anxiety. When deciding if depression is severe enough to warrant treatment it is important to involve patients in the decision-making process as their compliance is likely to be poor without this involvement.

Treatment

When deciding on treatment it is important to explain to patients that there may be a delay of three to four weeks before the antidepressants produce any noticeable improvement in their condition. However, it is important to make the point that response to antidepressants can be very good, especially in mild to moderate depression.

Antidepressants are not addictive and they do not lose their efficacy with prolonged use. It is widely recommended now that treatment should be continued for four to six months after clinical recovery to reduce the risks of relapse.

Some patients may be averse to taking prescription medication and evidence is emerging that St John's Wort is as effective as, and better tolerated, than high doses of imipramine in mild and moderate depression.

However, other antidepressants are contraindicated

while this medication is being used.

When deciding which drug therapy is indicated, it is important to assess the possibility of suicide, as it is well known that depression is associated with an increased risk of suicide. This will affect the choice of antidepressants. I frequently ask patients in a sensitive and non-threatening way if they have any thoughts of either self-injury or self-harm and find these useful screening questions.

As overdose is a common method of attempting suicide, it is safer to use the newer generation of anti-depressants such as selective serotonin reuptake

inhibitors (SSRIs). There can be considerable cardiotoxicity from overdoses of tricyclic antidepressants. My usual regime is to prescribe one or two weeks' supply of drugs in the first instance and then offer structured follow-up with regular contact with healthcare professionals.

I am always conscious when prescribing antidepressants that patients may well not be fully compliant with medication. I always attempt to involve the patient in the decision-making process, explaining to them that antidepressants are both effective and helpful in the

management of depression. My usual practice is to offer them a minimum of three months treatment, although evidence seems to be growing that long-term treatment can reduce the risk of relapse.²

I usually start with a low dose of tricyclic antidepressants (for example amitriptyline or dothiepin 25mg at night), building up over a period of 10 days to two weeks to a therapeutic dose (of 50-75mg at night in the elderly and 100-150mg in younger patients) and monitor the response.

Giving the whole dose at night makes maximum use of the sedating effect in helping patients to sleep, as sleep disturbance is a common feature of anxiety and depression. I am also careful to warn drivers that reaction time may be reduced and that they should make sure that they are driving within their capabilities.

In contraindicated patients or those who cannot tolerate the sedating effect of older antidepressants (eg HGV drivers, students, people in full-time employment), I would consider starting with an SSRI. I do not usually start treatment with the mixed-action serotonin and noradrenaline reuptake inhibitor but leave these for secondary care to initiate.

If it proves necessary to change between classes of antidepressants care should be taken to tail off and withdraw one agent before starting the next. This can help prevent cholinergic rebound if the first drug is a tricyclic. If both drugs increase the amount of serotonin there may be a serotonin syndrome, with nausea, abdominal pain, diarrhoea with dry mouth, and anxiety.

Withdrawal of antidepressant therapy, especially if it is abrupt, can cause an unpleasant rebound of symptoms, so the dose should be gradually reduced before stopping treatment.

Further interventions

In attempting to improve compliance rates with antidepressants I am conscious that the more information patients receive and the more involved they are in the decision-making process, the more likely they are to comply.

I try to offer a full explanation on the rationale behind the drugs and attempt to develop a supportive network of

Some factors that may influence the choice of antidepressants include the following:

1. Side-effects – the anticholinergic side effects of older tricyclics limit both their tolerability and compliance. Side effects include blurred vision, dry mouth, tremor or adverse effects on cognition or psychomotor function. Absolute contraindications include prostatism, glaucoma, cardiac disease and high suicide risk. It is recognised there may be withdrawal reactions on stopping tricyclics of minor sleep disturbance or increase in anxiety.

The SSRIs block the re-uptake of serotonin but have little or no effect on other neurotransmitters and so produce much fewer antimuscarinic effects than the tricyclics. Their main side effects are nausea, diarrhoea, headache, insomnia, agitation and sexual dysfunction. The newest antidepressants on the market are the selective serotonergic and noradrenergic reuptake inhibitors (SNRIs) such as venlafaxine. They also have few of the tricyclic side effects, but can cause insomnia, somnolence, sweating, impotence, postural hypotension or deranged liver function.

Monoamine oxidase inhibitors (MAOIs) are rarely used because of potential fatal interactions with other drugs and tyramine containing foods such as cheese, Bovril, broad beans or bananas.

2. Cost considerations – as both old and new antidepressants have been shown to be effective, the focus should be on safety and acceptability. The SSRIs are usually well tolerated, making it easier to reach an effective dose with better compliance. However, some patients develop an unpleasant hyperanxiety state, which can limit efficacy. Although new antidepressants are more expensive, cost-effectiveness studies have shown that they may be cheaper to prescribe in the long run as patients are more likely to comply with the full medication course and their illness is more likely to be treated effectively. The major brunt of the costs of treating depression are inpatient and outpatient care.

3. Tolerability – a meta-analysis of short-term studies has shown a 25 per cent lower drop-out rate because of side-effects and a 10 per cent drop-out rate overall when prescribing SSRIs compared with tricyclic antidepressants.¹ It has been suggested that sub-therapeutic doses of antidepressants are commonly used in primary care because of side effects that may limit their dose. However, there is a definite therapeutic response to low dose tricyclic antidepressants and the therapeutic relationship between doctor and patient can have a significant effect on helping improve depressive symptoms.

It is also important to consider referral to other agencies to help in the treatment of depression. These could include:

- community psychiatric nurses, who may have access to counselling or refer on to other agencies offering group therapy
- counsellors, increasingly available in primary care and are also available in the private sector
- in cases where there is a lack of response to first-line antidepressants some form of psychiatric assessment can be sought.

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◀ Continued from page 22

carers including the community psychiatric nurse, counsellors and myself.

When the patients collect their prescription from a local pharmacist they are given a leaflet explaining potential side effects and the need to continue taking medication for a minimum of two to three weeks to see any clinical benefit.

The leaflet also explains the need to be careful with alcohol and particularly driving, and offers useful advice on stress management.

We are running a pilot study with our local community pharmacist to assess whether this simple intervention of offering both advice and a leaflet at the time the prescription is collected, as well as telephone follow up and support at two and six weeks, will improve compliance rates.

We are quite hopeful, as this has been shown to work using specially trained nurses. But if pharmacists offered this facility it would be more likely to be delivered across the Health Service as a whole.

However, I maintain a healthy scepticism of patients' ability to comply with medication and fully accept that many do not complete a full therapeutic course of treatment. But at least we are aware of our shortcomings!

Cost comparisons for 28 days treatment based on maintenance dose and generic costs

TCA'S

Amitriptyline £2.14-£3.44
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SSRI'S

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Paroxetine £17.76-£31.16
Sertraline £16.20-£26.61

SNRI'S

Venlafaxine £23.97-£39.97

References

- 1 Anderson IM et al. Treatment discontinuation with selective serotonin reuptake inhibitors compared with tricyclic antidepressants - a meta-analysis. *BMJ* 1995; 310: 1188-91
- 2 Carney S, Geddes J, Davies D et al. Duration of treatment with antidepressants in depressive disorder (protocol).

Actionplan

1. Revise your knowledge of the core symptoms of depression. During the next two weeks carefully observe your clients (including both verbal and non-verbal signs). Can you identify patients who may be depressed? How many? What percentage?
2. In your practice workbook prepare a table with six columns headed: gender, prescriber, tricyclics, SSRIs, SNRIs and others. Over a two-week period record all scripts for antidepressants, filling in the details in the respective columns. Look at the ratio of male: female. Does it reflect the figure stated in the article? Is there any bias in your survey that may account for any significant variation?
3. Is there any evidence to suggest a specific doctor uses one class more than another? Discuss any trend with the prescriber to establish his or her reasons for preference.
4. In your practice workbook write a protocol to ensure you cover all the information required by patients when they collect their first prescription for an antidepressant. Is there any difference for the different classes of these drugs?
5. Using the above as a base, produce your own leaflet to explain the salient counselling points (need, continuity, onset of action, missed dose, side effects, signs which suggest stopping and seeing the prescriber, minimum length of treatment time etc).
6. Ask your local doctors if they are happy for you to give this leaflet out to their patients.

Risperidone for schizophrenia

Patients suffering from schizophrenia are less likely to suffer a relapse if treated with risperidone than if they are treated with haloperidol.

In a double-blind prospective study of adult outpatients with schizophrenia and schizoaffective disorder, 177 patients received risperidone and 188 haloperidol for a minimum of a year. The risk of relapse was 34 per cent and 60 per cent respectively.

Early discontinuation of treatment for any reason was more frequent in the haloperidol group. Patients taking risperidone also had greater reductions in the severity of psychotic symptoms and extra-pyramidal side-effects than those taking haloperidol.

The authors say that the reduced risk of relapse with risperidone could be due to its

superior efficacy, better tolerability or both.

The study, carried out by researchers in Washington and St Louis, USA is published in the *New England Journal of Medicine*.

Schizophrenia has a lifetime prevalence of 0.7 per cent in the USA and the economic burden was estimated at \$33 billion in 1990. Prevention of relapse, a major goal of schizophrenic treatment, would not only have physical and social benefits for patients but economic benefits for society, say the authors.

They also recommend that other new, atypical antipsychotics should be assessed individually for their ability to prevent relapses.

For more information:
www.nejm.com
NEJM 2002; 346: 16-22.

Women on OCs at greater risk of MI

Women who take second-generation oral contraceptives are at an increased risk of myocardial infarction, according to a study in the *New England Journal of Medicine*.

The risk in those taking third-generation pills, eg those containing desogestrel or gestodene, is inconclusive.

In a population-based, case-controlled study of 248 women in the Netherlands the risk of MI was similar among women who used OCs whether or not they had a prothrombotic mutation.

The authors say that since absolute risk of myocardial infarction is age-dependent, the risk associated with the use of oral

contraceptives will have the greatest effect in older women.

The most important advice to give these women is to stop smoking.

For more information:
www.nejm.org.uk
NEJM 2001;345: 1787-1793



Continued on page 26 ▶

Distance learning for pharmacists

Pharmacy Update for continuing education are reminded of the need to test. With the help of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice questions that appear to be inserted in the February 2 issue, which will cover this week's CPP-accredited CPD topics, with those in the January 19 and 26 issues.

For more information on the CPD service, contact Genus Pharmaceuticals on 01732 377269.

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Drugs and bugs

Two studies have been published in *The Lancet* investigating the links between non-steroidal anti-inflammatory drugs, *Helicobacter pylori* infection and the risk of peptic ulcers.

The first study, carried out at the University of Hong Kong, concluded that treating *H pylori* infection significantly reduced the risk of ulcers for patients beginning long-term NSAID treatment.

One hundred *H Pylori* positive patients who required treatment with NSAIDs were assigned to receive eradication treatment (51) or placebo (49).

Eradication treatment consisted of omeprazole 20mg, amoxicillin 1g and clarithromycin 500mg each given twice daily for a week.

The control group received omeprazole 20mg twice daily for a week. Diclofenac 100mg sustained release once daily was prescribed for six months at the same time.

Eradication was successful in 90 per cent of the treatment group and 6 per cent of the placebo group.

The six-month probability of ulcers was 12.1 per cent in the eradication group and 34.4 per cent in the placebo group and the probability of complicated ulcers was 4.2 per cent and 27.1 per cent respectively.

● The second paper was a meta-analysis of 25 previous studies looking at NSAID use, *H Pylori* infection and peptic ulcer disease. This concluded that there was synergism for the development of peptic ulcers between *H Pylori* infection and NSAID use.

The authors also said that peptic ulcer disease is rare in *H Pylori*-negative non-NSAID takers.

For more information:

www.thelancet.com

The Lancet 2002; 359: 9-23

Meningitis C vaccination programmes extended

The vaccine which protects against meningitis C will be made available to all people under the age of 25 following advice from the Joint Committee on Vaccination and Immunisation.

The vaccine, first introduced in November 1999, has been effective in reducing the number of cases of the disease and deaths in those under 20.

The campaign is being extended to include 20-24 year olds as the overall risk of meningococcal infection is still

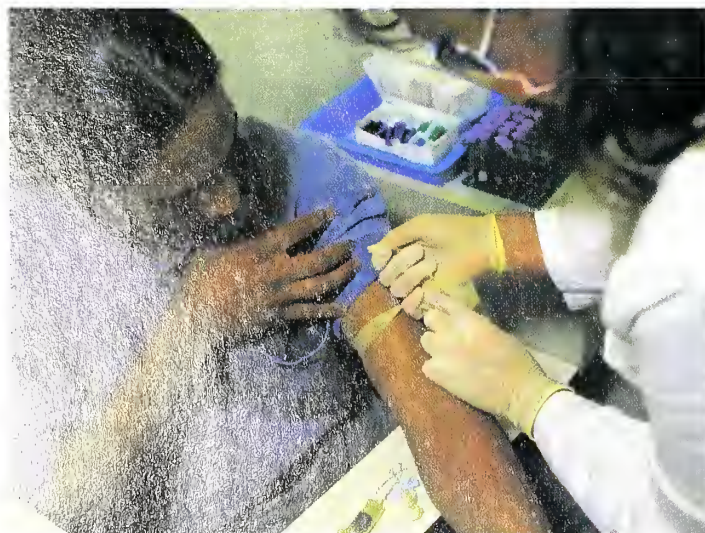
twice as high in this age group compared to the general adult population.

● The whooping cough vaccine is to be added to the pre-school booster vaccine given to children in Scotland. A combined diphtheria, tetanus and acellular pertussis vaccine will replace the diphtheria and tetanus booster following advice from the JCVI.

For more information:

www.doh.gov.uk

www.scotland.gov.uk



Trouble with breathing

Smokers with a persistent cough do not realise that it may be an early warning sign of chronic obstructive pulmonary disease (COPD), according to a survey published by the British Thoracic Society COPD Consortium.

The survey of more than 800 members of the public revealed that 22 per cent of smokers suffered from a persistent cough and yet more than 80 per cent had not seen a doctor. The survey revealed that:

● there is a low level of recognition of the early warning signs of COPD

● 61 per cent have experienced one or more possible COPD symptoms

● 45 per cent of smokers said they did not go to their GP about symptoms as they did not want to be told to give up smoking.

The BTS Consortium has re-launched an educational campaign targeted at middle-aged smokers called *Trouble With Breathing?*. This encourages people to see their GP if they have key

symptoms eg breathlessness on mild exertion, frequent coughs, colds and persistent production of phlegm.

There are an estimated 600,000 cases of COPD in the UK but, according to the BTS, this figure could represent the "tip of the iceberg", due to the lack of awareness among the public.

For more information:

www.brit-thoracic.org.uk



Smokers sometimes suffer from chronic lung disease without realising it

Painkillers can exacerbate chronic renal failure

Regular use of aspirin or paracetamol can exacerbate chronic renal failure, a study in the *New England Journal of Medicine* has found.

In a nationwide, population-based case-controlled study of Swedish patients newly diagnosed with renal failure, aspirin and paracetamol were used regularly by 37 and 25 per cent respectively of patients and by 19 and 12 per cent respectively of the controls.

The relative risks rose with increasing cumulative lifetime

doses and more consistently with paracetamol use than aspirin.

However, the authors warn that these analgesics may have been taken to relieve the symptoms of conditions that can predispose patients to renal failure, making it impossible to rule out bias. They conclude that it is unclear which is the cause and which is the effect.

For more information:

www.nejm.org.uk

NEJM 2001; 345: 1801-1808

Rofecoxib for OA of the knee

Rofecoxib has been shown to be more effective than celecoxib or paracetamol for treating osteoarthritis of the knee in a study published in the *Journal of the American Medical Association*.

In a randomised, double-blind trial, 382 patients were assigned to receive rofecoxib 12.5mg or 25mg a day, celecoxib 200mg a day or paracetamol 4g a day.

Relief from pain on walking at six days was greatest in the

rofecoxib 25mg group followed by rofecoxib 12.5mg, celecoxib and paracetamol respectively.

At six weeks the pattern was similar for relief of all symptoms including night pain, stiffness and physical function. There were no significant differences in the incidence of clinical side-effects.

For more information:

jama.ama-assn.org

JAMA 2002; 287: 64-71

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Northern Ireland pharmacists enrolling for Update before the end of February will have their registration fee paid by the NI Centre for Pharmacy Postgraduate Education and Training.

Just complete the coupon and send it with a cheque for £20.00 (£17.02 + VAT). Alternatively, call Mary Prebble on 01732 377269 with your credit card details. This will register you for 12 months' worth of certificated marking. After February 16, the standard registration fee for Update will be £25.00.

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Frontshop

Flight Socks are ready for take off

SSL International is launching Class 1 compression socks in its Scholl Flight Socks range.

The socks provide a compression level of 14-17mmHg, for people at a higher risk of developing deep vein thrombosis who may need a greater level of support.

Scholl Flight Socks Class 1 are available in three sizes – standard, large and extra large.

The packaging carries clear guidelines to aid correct recommendation. Measurement of

the foot length, ankle and calf is required to ensure the correct size is selected.

The Scholl Flight Socks range will be supported with a consumer education and awareness programme including national press advertising. A range of pharmacy educational material is available from this month.

Price: £11.95

Pip code: standard 283-4000, large 283-4026, extra large 283-4034

SSL International plc

Tel: 0161 654 3000.

Levonelle campaign to raise public awareness

Schering Health Care is supporting its Levonelle emergency hormonal contraception with an £800,000 advertising campaign designed to raise awareness of the product's availability from pharmacies.

Two advertisements – "missed pill" and "split condom" – will appear in women's magazines from February.

The advertising will also be used in poster format in pharmacies and in women's toilets located in bars, clubs and cafes.

The aim of the campaign is to help inform women that the sooner they take Levonelle after unprotected sex, the more likely the product is to work.

Schering Health Care says that increased awareness of emergency contraception will mean more women seeking it from pharmacy and from their GP or family planning clinic when they need it.

For more information:

Schering Health Care Ltd
Tel: 01444 232323.

Beginning of a new era for Kimberly-Clark

Kimberly-Clark is improving its Huggies Beginnings nappies for newborn nappies.

Huggies Beginnings now feature a double action absorbent system that draws wetness away from the baby's skin, providing better dryness and comfort.

The launch will be supported by

a Huggies TV advertising commercial. The TV campaign is part of a £30 million support plan which also includes press advertising and a "continued relationship" marketing campaign.

For more information:

Kimberly-Clark Ltd
Tel: 01732 594000.

All change for Radian B

Pharmacia has appointed Chemist Brokers to handle all sales of its topical pain reliever, Metanium nappy rash cream, Valderma cream and Valpada athlete's foot treatment. The move follows the acquisition of these products from Roche Consumer Health Products Ltd.

For more information:

Chemist Brokers

Tel: 0151 571 2500.



TVnext week

Anadin Extra: All areas

Bassett's Soft & Chewy Vitamins: GMTV, C5, Sat

Benylin Active Response: GTV, STV, A, HTV, W, C4, Sat

Benylin cough range: All areas except U, CTV, TSW

Blistex: GMTV

Breathe Right mentholated nasal strips: All areas except GTV, CTV, LWT, C4 TSW

Covonia: GMTV, C5

Flu Plus: All areas except U, CTV, TSW

Full Marks Mousse: All areas + Sat

Fybogel: GMTV, Sat

Gaviscon Tablets: All areas

Imodium: All areas

Just for Men: All areas

Kalms: GMTV, Sat

Lucozade: All areas except U, CTV, TSW

Meltus: All areas + Sat

Neutrastate: G, Y, A, M, LWT, TT, C4

Nicorette: All areas

NiQuitin Lozenge: All areas except U, CTV, TSW

NiQuitin Patch: All areas except U, CTV, TSW

Nivea Hand Age Defying Crème Q10: All areas

Olbas: C5, GMTV, Sat

Pepcidtwo: All areas except GTV, B, CTV, TSW

Seabond Denture Fixtures: All areas

Senokot: All areas

Sensodyne Total Care toothpaste: All areas

Seven Seas Cod Liver Oil: G, Y, A, M, LWT, TT, C4

Sudafed: All areas except U, CTV, GMTV, TSW

Throaties Pastilles: GMTV

Venos: GMTV

Zovirax: C4, C5, Sat

PharmaSite for next week: NiQuitin – Window, NiQuitin – In-store, Covonia – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Cough, cold & flu FORECAST



KEY FACTS

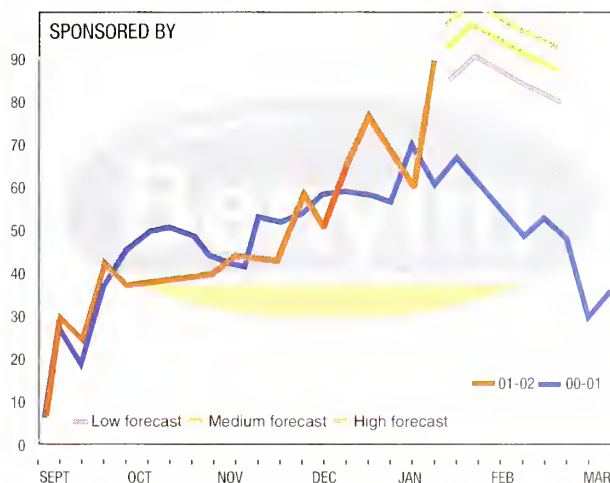
- Last week saw a sharp increase in the levels of respiratory illness in the UK
- Incidence of respiratory illness is above that seen this time last year
- *Coughing* is the most prevalent symptom

Benylin

Continue on Alert

Information updated weekly by SDI

SPONSORED BY



Scriptlines

Colgate launches oral paste

Colgate launched Duraphat 2800 Fluoride Toothpaste (sodium fluoride 0.619 per cent, 2800ppmF) on January 1.

It is indicated for the prevention and treatment of dental caries (coronal and root) in adults and children over 16 years. The recommended method of use is to apply a 1cm line of paste to the toothbrush and brush the teeth thoroughly for one minute morning and evening. Any residue should be spat out after use. Patients are advised not to drink or rinse for 30 minutes after use.

The product, which is a Prescription Only Medicine, can be obtained direct from the company or from dental wholesalers, although the company hopes to have the product stocked in pharmaceutical wholesalers soon.

Price: £2.86 exc VAT

Pack size: 75ml

Pip code: 285-0345

Colgate-Palmolive,

Tel: 01483 302222.

Voltarol Optha update

Novartis has announced additional indications for Voltarol Optha (diclofenac sodium 0.1 per cent). The eye drops are now indicated for:

- The treatment of inflammation and discomfort after strabismus (squint) surgery – at a dose of one drop four times daily in the first week, three times daily in the second week, twice daily in the third week and as required in the fourth week.

- The treatment of ocular pain and discomfort after radial keratotomy – one drop is applied before and immediately after surgery and then one drop four times daily for up to two days.

As squint surgery is normally performed in children, the warning that there was no experience of use in children has now been deleted from the SmPC.

For more information:

Novartis Pharmaceuticals

Tel: 01276 692255.

NHS
SCOTLAND

Practitioner Services - Pharmacy

PRESCRIPTION PRICING

Following the shortage of generic drugs in 1999 together with the introduction of a new processing and pricing system for Scottish prescriptions there was, in the early part of 2001, a four month delay in prescription pricing. In April 2001 the Common Services Agency made a commitment to the Scottish Executive Health department and the Scottish Primary Care Trusts and Health Boards that this backlog would be eliminated by the end of November 2001.

We are pleased to report that this ambitious target was achieved on Thursday 29 November and that payments are back on target.

We would like to take this opportunity to thank all our dispensing contractors for their patience and understanding during this difficult period.

Cold and flu sales are not to be sneezed at

As part of a series of product category reviews, Information Resources analyses the cold and flu decongestants market in pharmacies. Each month a different pharmacy expert comments on how the product category is performing

The cold and flu decongestants market is worth £160.7 million and sales through pharmacies (including Boots and Superdrug) account for £99.8m.

The market is split into two sectors, oral and nasal, with sales of oral decongestants worth £73.7m and nasal at £26.1m.

Overall sales declined by 4.4 per cent in the year ending 4 November 2001 and by 7.9 per cent through pharmacies. The decline is partly due to a slower start to the current season.

There has been no real sign that retailers have taken full advantage of the abolition of RPM. However, as the season progresses we may still see some discounting.

Consumers tend to be particularly loyal within this sector as they seek reassurance from products they trust, so it is little surprise that the current top five brands are the same as last year.

The number one ranked brand in the oral decongestants sector is Reckitt Benckiser's Lemsip Max



Strength. Two extensions have been introduced to the Lemsip brand in the past year – Lemsip Children's Vapo-Patches and Lemsip Pharmacy Non-Decongestant Formula.

The second largest brand is GlaxoSmithKline's Night Nurse. GSK's Day Nurse, Beechams Powders and Beechams Flu Plus also feature in the top 10.

With the successful launch of Pfizer's Sudafed Dual Relief, currently ranked twelfth, it will be interesting to see the progress of the recently introduced Sudafed Dual Relief Max.

The leading brand in the nasal

decongestants sector is Lane Health Products' Olbas which was introduced to Europe over 100 years ago.

Novartis Consumer Health's Otrivine Adult Formula is ranked second but is showing some decline year-on-year. The Sinusitis variant also figures in the top 10 and continues to show growth.

Dendron's Happinose has shown the largest growth year-on-year, with sales increasing by 19.6 per cent in the last year.

The leading brand aimed specifically at children is Crookes Healthcare's Karvol, ranked fourth with sales slightly down.

are the big advertisers who succeed in getting both consumers and pharmacists on their side. Cold and flu products need the reassurance of professional endorsement. Manufacturers have to get their brands in front of the consumer but it is also essential to acknowledge the role of the pharmacist.

The effect of supermarket competition on community pharmacy hasn't hit yet. We had a phoney war in the initial period after the demise of RPM. Over Christmas, the supermarkets' major push was to get people into their stores to buy luxury goods.

It is no good for pharmacies to take a "do-nothing, head-in-the-sand" attitude. Unless we follow the supermarkets and make some tactical price reductions on key lines to show that we are price-competitive, I am concerned about the future of pharmacy. We

must be pro-active and look at what our local competition is doing. Don't make the mistake of thinking that because you are in a village and the nearest supermarket is five miles away, that you don't need to do anything. The next 12 months will be critical and it is inevitable that the supermarkets will gradually nibble away at the little guys if we don't defend our position.

Work with the OTC companies to achieve some reductions, although not three-for-two offers. In my opinion, Boots' three-for-two promotion is utterly disgraceful and undermines the P category. Pharmacies should make a big issue of supporting medicines and support the P category very hard.

It's important to make cold and flu products visible to the consumer to attract sales. I have found it very effective to take out regular full-page advertisements in

Top pharmacy brands

Nasal decongestants

1. Olbas
2. Otrivine Adult Formula
3. Vicks Vaporub
4. Karvol
5. Vicks Sinex
6. Vicks Inhalers
7. Happinose
8. Sudafed
9. Otrivine Sinusitis
10. Snuffle Babe

Oral decongestants

1. Lemsip Max Strength
2. Night Nurse
3. Sudafed
4. Lemsip Powders
5. Day Nurse
6. Sinutab
7. Beechams Powders
8. Beechams Flu Plus
9. Contac 400
10. Nurofen Cold & Flu



Graham Phillips, director of Manor Pharmacy Group

“Sales of cold and flu decongestants are fairly buoyant but not exceptional and appear to be following a similar pattern to last year. There is no real evidence of a flu epidemic although there are plenty of coughs, colds and sore throats around. Could the Government's flu vaccination programme be starting to bite?”

Best sellers this year are tablets and capsules because of their portability and convenience. My impression is that these formats are possibly doing well at the expense of liquids.

Some product extensions have been launched in ranges such as Sinutab. It has created brand growth. There has been some interest in lozenges (eg Lemsip and Day Nurse) and these have helped to grow the marketplace without undue cannibalisation.

Increasingly, the brand winners

local newspapers promoting the pharmacy as a "Cold and Flu Advice Centre".

If we take a pro-active approach, there is a positive outlook for cold and flu product sales in pharmacies. If not, the market will go elsewhere so we need to protect ourselves now.”



Graham Phillips: make cold and flu products visible

WEED KILLER

New NiQuitin CQ 4mg Lozenges offer unsurpassed NRT quit rates

When your customers want to quit once and for all, you might be their best chance.

For those who normally smoke within 30 minutes of waking, a recommendation for new

NiQuitin CQ 4mg Lozenges can triple their chances of quitting compared with placebo.

What's more, success rates with good compliance can be over five times greater than with placebo.^{1*}

With NiQuitin CQ 4mg Lozenges you offer a success rate unsurpassed by any other form of NRT.^{1,2}

End of story.

*Measured at 6 weeks, users taking more than the median dose (8.2 4mg Lozenges per day) during the first two weeks of treatment.



NiQuitin CQ™ 2mg Lozenge
available for those who smoke
after 30 minutes of waking

Help bring smoking to a full stop

NiQuitin CQ Lozenge Product Information. Presentation: White, round lozenge, available in two strengths: NiQuitin CQ 2mg Lozenge containing 2mg nicotine (as 11.1mg nicotine polacrilex) marked NL2 on one side and NiQuitin CQ 4mg Lozenge containing 4mg nicotine (as 22.2mg nicotine polacrilex) marked NL4 on one side. Indications: Relief of nicotine withdrawal symptoms, including craving, associated with smoking cessation. If possible, use with a stop-smoking behavioural support programme. Dosage and administration: Adults: Users must stop smoking completely. NiQuitin CQ 2mg Lozenges are suitable for those who smoke 30+ mins after waking and NiQuitin CQ 4mg Lozenges are suitable for those who smoke within 30 mins of waking. Treatment is in 3 steps. Step 1 (weeks 1 to 6), start with 1 lozenge every 1 to 2 hours. Step 2 (weeks 7 to 9), step down to 1 lozenge every 2 to 4 hours. Step 3 (weeks 10 to 12), step down to 1 lozenge every 4 to 8 hours. Over the next 12 weeks, use 1 to 2 lozenges per day only on occasions when strongly tempted to smoke. During weeks 1 to 6 it is recommended that users take a minimum of 9 lozenges per day. Users should not exceed 15 lozenges per day. Do not use for more than 24 weeks (6 months); if users still feel the need for treatment, they should consult a physician. Place 1 lozenge in the mouth and allow to dissolve. Periodically move the lozenge from side to side in the mouth until completely dissolved (approximately 20–30 minutes). Do not chew or swallow whole. Do not eat or drink while a lozenge is in the mouth. **Contraindications:** Use by non-smokers, children and adolescents under 18. Those with: phenylketonuria, recent heart attack or stroke, severe irregular heartbeat, unstable or worsening angina, resting angina. Hypersensitivity to nicotine or any of the ingredients. **Precautions:** Use only on doctors' advice if the user has hypertension, peptic ulcer, severe kidney or liver impairment, pheochromocytoma, hyperthyroidism, diabetes, cardiovascular disease (e.g. heart failure, stable angina, cerebrovascular disease, vasospastic disease, occlusive peripheral arterial disease). For sufferers of phenylketonuria – contains aspartame which metabolises to phenylalanine. For those on a low sodium diet – each dose contains 15mg sodium. Users with active oesophagitis, oral or pharyngeal inflammation, gastritis or peptic ulcer may experience symptom exacerbation.

No known effects on ability to drive but smoking cessation itself can cause behavioural changes. **Interactions:** Concomitant medication may need dose adjustment; caffeine, theophylline, imipramine, pentazocine, phenacetin, phenylbutazone, insulin, tacrine, clomipramine, olanzapine, fluvoxamine, flecainide and adrenergic blockers (e.g. propranolol) may need dose decrease; adrenergic agonists (e.g. salbutamol) may need dose increase. Propoxyphene, frusemide and H₂-antagonists may also require dosage adjustment as smoking may alter their effects. **Side effects:** Adverse reactions may be similar to those caused by the effects of nicotine which are dose dependent, or from smoking cessation. Headache, dizziness, mood swings, irritability, anxiety and insomnia can occur, and may also be due to nicotine withdrawal. Commonly reported adverse events include nausea, vomiting, dyspepsia, hiccup, flatulence, diarrhoea, constipation, appetite changes, mouth irritation/ulceration, pharyngitis, coughing, wakefulness. Uncommon adverse events include general malaise, skin rashes, itching, sweating, gingival or nose bleed, palpitations, tachycardia, chest pain, flushing, nasal or throat irritation, chest infection, dyspnoea, asthma exacerbation, taste disturbance, halitosis, gagging, lip soreness or ulceration, tooth or jaw ache, desophaegeal reflux, peptic ulcer, abdominal cramps, excessive thirst, nocturia, tight-headedness, nightmares, restlessness, migraine, convulsions, sensory disturbance, unconsciousness. **Pregnancy and lactation including trying to become pregnant:** Pregnant or nursing women should be advised to try to give up smoking without nicotine replacement therapy, but should this fail, a medical assessment of the risk/benefit should be made. **Legal category:** P. **Product licence number:** NiQuitin CQ 2mg Lozenge, PL 00079/0369; NiQuitin CQ 4mg Lozenge, PL 00079/0370. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack size and RSP:** 36's £8.99; 6's £1.74. **Date of last revision:** September 2001. **NiQuitin CQ** is a registered trademark of the GlaxoSmithKline Group of Companies. **References:** 1. Data on file, GlaxoSmithKline. 2001. 2. Stiller C, Mannix B, Fowler J, et al. Nicotine replacement therapy for smoking cessation (Cochrane Review). In: The Cochrane Library, issue 1, 2001. Oxford: Update Software.

New guidelines advocate self-medication

For those people who experience a sudden onset of diarrhoea, the pharmacist is normally the first point of contact for advice and treatment. A bout of diarrhoea can be uncomfortable and socially disruptive if left untreated – it is no surprise that research has found that diarrhoea is one of the leading reasons for absenteeism from work, often as a result of non-treatment.

One reason why many people fail to treat is because the advice available to pharmacists and their customers has been confused and contradictory. In many cases this has led to effective treatment being delayed or withheld unnecessarily, often prolonging the diarrhoea and the disruption to normal life.

In response, a new set of guidelines on the management of acute diarrhoea by self-medication*, intended for use by pharmacists, GPs, nurses and travel advisory services, has been published by an international panel of gastroenterologists. The guidelines aim to provide authoritative advice and to dispel the myths and confusion surrounding the treatment of acute diarrhoea.

Safe and effective treatment of acute diarrhoea

The view of the Panel is that self-medication of acute

diarrhoea relieves discomfort and social disruption, and is safe and effective for otherwise healthy adults. Loperamide (2mg) is considered the treatment of choice, providing that the sufferer is otherwise fit and healthy, aged over 12 years and shows no sign of fever, blood in stools, severe vomiting that could lead to dehydration, or obvious dehydration. The frail or elderly (>75 years) should only be treated under medical supervision.

Dispelling the myths

The decision to refrain from treatment was undoubtedly influenced by the commonly-held view that diarrhoea is a defence mechanism and therefore should not be treated with anti-diarrhoeal drugs that reduce stool output. The Panel firmly rejects the belief that you should let diarrhoea run its course as a myth, stating that it is: "Reminiscent of the medieval paradigm for the expulsion of toxins by methods, such as phlebotomy."

The Panel goes on to state: "There is no evidence to suggest that diminishing stool output in adults prolongs the disorder." Indeed it concludes: "The balance of evidence suggests that anti-diarrhoeal medication may diminish diarrhoea and shorten duration."

Even where the cause is an infection, diarrhoea is an involuntary response to irritation and inflammation, and cannot be thought of as nature's way of purging the body of infection. A diarrhoea remedy will simply help ease discomfort, reduce dehydration and help restore the system to normal quickly.

The Panel concluded that although essential in infantile diarrhoea, there is no evidence that oral rehydration treatment (ORT) can relieve or shorten the duration of the diarrhoea illness, and ORT is not needed in otherwise healthy adult sufferers.

Best practice – oral loperamide is the treatment of choice

As a result of this new consistency of guidelines, customers entering their pharmacy for help and advice on acute diarrhoea can confidently be recommended loperamide treatments, such as Imodium and Imodium Plus. Diarrhoea treatments, such as Imodium, are specially formulated to offer fast and effective relief from diarrhoea, allowing sufferers to take practical steps to manage and control their condition.

* Wingate D et al. *Guidelines for adults on self-medication for the treatment of acute diarrhoea. Alimentary Pharmacology and Therapeutics* 2001; 15:773-782



STOP PRESS!

The most recent edition of the BNF has a revised section on acute diarrhoea, reflecting changes in thinking concerning symptomatic treatment. It is now stated that "Antimotility drugs relieve symptoms of acute diarrhoea" and are used "in the management of uncomplicated acute diarrhoea."

ESSENTIAL INFORMATION
IMODIUM[®]

For further information contact the PL holder (see below)

Presentation: Capsule containing loperamide hydrochloride 2 mg

Indications: Symptomatic treatment of acute diarrhoea. **Contraindications:** Hypersensitivity to any component of the product. **Price:** 2 capsules £1.00, 6

capsule GSL £3.15, 8 capsules £3.95, 12 capsules £5.35, 18 capsules £6.70. **Legal category:** P (8/12/18 capsules), GSL (2&6 capsules). **PL no:** 0242/0028. **PL**

Holder: Janssen-Cilag Limited, Saunderton, High Wycombe, Bucks HP14 4HJ.

for the treatment of acute diarrhoea



Imodium, formulated with loperamide, is the UK's best-selling product for diarrhoea. Just one dose can bring effective relief, so that the sufferer can manage their condition and confidently get on with their life. It is also the preferred treatment for diarrhoea as a symptom of irritable bowel syndrome (IBS) as it can be taken over a long period of time. Available in 6, 8, 12 or 18 capsules and liquid format.

Imodium Plus is formulated with loperamide (relief of diarrhoea), and simethicone (anti-flatulent) that helps to disperse the intestinal gas that causes stomach cramps, bloating and wind. Its unique combination works to stop diarrhoea by slowing your digestive system back to its normal speed and restoring its natural balance. It is available in 6, 8, 12 and 18 chewable tablet format.

Summary of Guidelines for the Management of Acute Diarrhoea in Adults by Self-Medication

- Acute uncomplicated diarrhoea is commonly treated by self-medication.
- Treatment of acute episodes relieves discomfort and social dysfunction and does not prolong the illness. Self-medication in otherwise healthy adults is safe and should not be withheld.
- Loperamide 2mg is the treatment of choice. Other anti-diarrhoeal drugs have uncertain efficacy and carry a greater risk of unwanted adverse effects.
- Fluid intake: an adequate fluid intake should be maintained, indicated by thirst. Drinks containing glucose or soups rich in electrolytes are recommended.
- Oral rehydration solutions, although essential in infantile diarrhoea, do not relieve diarrhoea and confer no added benefit for adults who maintain their fluid intake.
- Food intake: consumption of solid food should be guided by appetite; small light meals are recommended.
- Probiotic agents: not widely available at present; available evidence does not support their use in early treatment.
- Antimicrobial drugs: available without prescription in some countries, are not generally appropriate for self-medication, except for travellers on the basis of medical advice prior to departure.
- Medical supervision is recommended for the management of acute diarrhoea in the frail, the elderly (>75years), persons with concurrent chronic disease, and children under 12.
- Medical intervention is required when there is no abatement of the symptoms after 48 hours or when there are warning signs such as obvious dehydration, abdominal distension, or dysentery (pyrexia >38.5°C and/or bloody stools).

If you would like to receive a copy of the guidelines please call the Imodium helpline on 0870 2412406.

ESSENTIAL INFORMATION

IMODIUM™ PLUS

For further information contact the PL holder (see below)

Presentation: Chewable tablet containing Loperamide Hydrochloride 2 mg and Simethicone equivalent to 125 mg polydimethylsiloxane. **Indications:** Symptomatic treatment of acute diarrhoea associated with gas related abdominal discomfort. **Contraindications:** Hypersensitivity to any component of the product. **Price:** 6 tablets £3.45, 12 tablets £5.75 and 18 tablets £7.95. **Legal category:** P. **PL no:** 13249/0020. **PL Holder:** Johnson & Johnson (MSD Consumer Pharmaceuticals, Enterprise House, Station Road, Loudwater, High Wycombe, Bucks HP10 9UF).

Global sum in a spin

LPC secretary **Hemant Patel** explains some of the flaws in the global sum method of payment

The imposition of the global sum and resultant decrease in the dispensing fee by 10 pence per prescription for contractors in England and Wales has serious implications for both pharmacy owners and the public.

Unless the remuneration system and its inherent inadequacies and limitations are understood by all, and action is taken to put a new system in place as soon as possible, there is a real potential for hardship. The imperfect global sum method of payment puts not only the safety of patients at risk, but also the reputation of the profession.

In her letter to pharmacists, the health minister, Hazel Blears, boasted of a real increase of 4 per cent in dispensing fees over the past decade. Bank interest on capital invested and locum work would have yielded a better result.

At a simple level, the dispensing fee could be regarded as global sum minus professional allowance divided by number of prescriptions dispensed. If, in real terms, it does not grow then there is "attrition", and hardship for those who rely mainly on dispensing income.

With an estimated two thirds of any global sum increase going to only 40 per cent of contractors, more and more become "financially asphyxiated". How can contractors consider improving quality when placed in an increasingly precarious position?

The number of prescriptions dispensed by chemist contractors in England and Wales has increased from 370,339,487 in 2000/01 to an estimated 400,000,000 in 2001/02 (+60.8 per cent). While total remuneration has increased from £504.7 million to £510.0 million for the same period (+1.0 per cent).

The Retail Price Index for the same period has increased from

Year Pharmacy	1 Rx	2 Rx	3 Rx	4 Rx	Monthly income in year 4 (% £Share) (Income if fee value is preserved)
Pharmacy A (+ 8% per year)	4,000 (25%)	4,320	4,666	5039 (29%)	£4,654.52 (29.1%) (vs £5,039)
Pharmacy B (+ 5% per year)	4,000 (25%)	4,200	4,410	4,631 (26.7%)	£4,277.66 (26.7%) (vs £4,631)
Pharmacy C (+ 0% per year)	4,000 (25%)	4,000	4,000	4000 (23%)	£3,694.80 (23.1%) (vs £4,000)
Pharmacy D (-3% per year)	4,000 (25%)	3,880	3,764	3651 (21.1%)	£3,372.43 (21.1%) (vs £3,651)
Total Rx	16,000	16,400	16,840	17,321	
Fee (£)	1.00	0.9756	0.9501	0.9237	Note: £16,000 spent in total each year All pharmacies are 'underpaid'

112.3 to 175 (+55.8). So, when adjusting for volume increases and RPI, the prescription fee has decreased by around 55 per cent in real terms.

The prediction for the average volume growth in the next three years is at least 50 per cent higher than the average of the last decade, largely because of the National Service Frameworks for Coronary Heart Disease and Diabetes (6.0 vs 3.7 per cent).

The net ingredient cost of prescriptions has increased for the same period from 507.26p to 1008.58p (+98.8 per cent). As drug costs are rising by around 10-12 per cent there is cash tied up in stock and in funding the NHS as the full payment is only due after 90 days.

This means that the stockholding for Pharmacy B (still at an average of two months in the example below) has increased from £80,000 to £126,791 in three years due to volume increases and inflation. This can only be funded by introducing new capital, cutting staff hours, or decreasing the proprietor's drawings to financially support the pharmacy.

If the dispensing fee in year one is £1, in subsequent years it will continue to reduce as volume increases. To illustrate the point,

let us consider four pharmacies with exactly equal monthly prescription volume – say 4,000 in year zero.

Pharmacy B increases volume by the average 5 per cent; Pharmacy A increases volume by 3 per cent over the average; Pharmacy C remains static, while Pharmacy D loses 3 per cent volume.

The Government only appears to be interested in increased productivity at no additional cost to the NHS. However, there is a cost attached to the dispensing of prescriptions that is borne in increasing amounts by all pharmacies.

Pharmacists do not write prescriptions and therefore cannot increase "productivity", but the public still needs the service. Prescription numbers may go down due to following risk factors:

- GP incentive schemes
- "incentivised" receptionists directing prescriptions
- poor service
- loss of nursing home business.

There is also a more fundamental point: pharmacies in health authorities with controlled prescribing are losing out to pharmacies in other areas. Funds are transferred without planning

from one health authority to another to pay dispensing fees, without taking the actual needs of pharmacies or patients into account.

Over time such situations are leading to unplanned closures, making it difficult for health authorities to discharge their statutory duty of maintaining an accessible network of pharmacies.

Pharmacist is competing with pharmacist, and they are all chasing volume instead of delivering high quality services to improve health. Many pharmacies will be hindered in developing services or premises in the future as their income



"A large number of pharmacies will be under pressure to cut costs"

decreases year by year.

Pharmacy C is over £305 per month adrift in dispensing fees within three years for doing exactly the same volume of work. What an incentive for pharmacists to develop professionally when they are required to work the treadmill harder just to stand still!

As overheads continue to rise, due to increases in drug costs, staff costs (increasing at 6 per cent a year) and general business expenses, the breakeven point rises and the net profits decrease dramatically. Disastrous consequences lie ahead for Pharmacy C, if it fails to grow volume or worse still continues to lose volume to competitors.

At a time when staff and training costs are likely to rise, a large number of pharmacies will be under pressure to cut costs. In such circumstances patient safety will be compromised.

How can anyone say that the current inadequately funded Global Sum contract for pharmacy, which is further hindered by heavily skewed distribution of meagre increases, is a fair and just way to compensate pharmacy?

As discounts follow similar patterns, there is an urgent need to instil confidence in embattled contractors who are all deeply concerned about pharmacy viability. At present "cannibalism" is the only way to grow business.

why **SPRAY** for sore throat pain?



A spray is an ideal treatment for sore throats. Ultra Chloraseptic Sore Throat Spray:

TARGETS THE PAIN... Unlike anaesthetic lozenges which can numb the entire mouth, Ultra Chloraseptic's easy to use unique swivel head applicator delivers the active straight to the site of the pain thus minimising the anaesthetic effect on the rest of the mouth.

WORKS IN SECONDS... Ultra Chloraseptic contains Benzocaine, well known for its rapid-acting local anaesthetic effect. Just 3 sprays brings relief to sore throats in seconds.

*Source: AC Nielsen Retail Audit, August 2001

ULTRA CHLORASEPTIC:

Active Ingredient: Benzocaine 0.71% • Indications: Symptomatic relief of sore throat pain

• Legal Category: P • Further information is available from Prestige Brands (UK) Ltd, 3 Scotland Drive, Farnham Common, Slough, Berkshire SL2 3ES

UK's No.1 Throat Spray*
Original fast-acting formula

Slim down and

Peter Cattee, managing director of Peak Pharmacy, explores some simple stock management techniques designed to allow pharmacists to experiment

In my last article I suggested that the majority of pharmacies in this country carried too wide a product range, and often too great a depth of stock.

If that is the case, then it rather begs the question of whether those pharmacists really need larger premises to better display their range.

While this may be an option for a small number of pharmacists with an interest in retail, for the majority more prudent management of stock may well provide the opportunity to improve margins through stock rationalisation.

To achieve this, pharmacists must have good information about what they are selling, as well as a basic plan about how to use this information.

The easiest, but unfortunately the most expensive, way to collect this data is using an EPoS system.

Anyone who aspires to good business discipline should consider adopting such a system. Used properly, they introduce excellent control, and gold standard information.

However, when one is not used properly, it is a time-consuming luxury that will gradually become a very expensive till.

As far as the single proprietor is concerned, particularly one with limited retail potential and doubts about using EPoS, a viable alternative may be the use of a multi-function till, and a well-organised stock control system.

In essence, an EPoS system is a till with an electronic stock book attached to it.

While it may be time-

consuming to use a traditional stock book it also has the advantages of regular stock review and passing the responsibility to staff rather than the computer.

Another option may be to consider using wholesaler-compiled data of purchases. Obviously this is only useful if the majority of purchases are made from one source, but it can be particularly helpful in tracking information on faster selling or larger volume lines.

Unfortunately it is a rather blunt instrument for detailed stock analysis when considering larger outer sizes and the woefully slow rate of sale of some items.

However, the recent introduction of schemes to encourage the purchase of singles rather than outers, and improved information systems may well see significant improvements to provide what could be almost virtual EPoS data.

Analysing information is the key to improving stock control, irrespective of how the information is generated

In this sense a simple category approach will give an immediate indication of the relative strengths and weaknesses of the business.

Division of sales into the major



then be carried out, for instance identifying dental, haircare, skincare, GSL and P medicines, photographic etc, until a fairly basic model of the shop is formed.

Matching space occupied by categories against sales is probably the most effective method of managing stock in any pharmacy.

A strict rule needs to be imposed that each group will not exceed its allotted space unless there is a distinct plan to increase sales accordingly.

Generally, pharmacies find it much easier to introduce stock than to eliminate it. A simple but useful way to manage this process is that for every line coming in one must go out.

Divide your stock up into these major groups, and perhaps 15 categories below them and you will have all the information you need to make the important decisions about the retail future of your business.

Now start to present your stock in a manner that reflects the

groups of medicines, toiletries, health and vitamins, baby and other will give a quick picture against readily available market data supplied by wholesalers and trade organisations.

At the same time existing fixtures should be measured, and the approximate amount of space taken up by each category identified.

Quantifying a linear sales area for each category and plotting it against sales will provide a quick indication of whether current merchandising practises are at least starting from the right place.

Further sub-categorisation can

Analysing information is the key to improving stock control, irrespective of how the information is generated"

streamline

"If you can view a group of products together on the shelf, it is easy to identify the 'must stock' lines"



Looking at individual categories, or indeed sub-categories, is also a helpful way to make more logical decisions on stocking policy.

For instance, if you can view a group of products together on the shelf, it is easy to identify the "must stock" lines which sell themselves.

But once these have been displayed can you account for the presence of the other lines, and how many of them are really only competing with each other for shelf space, rather than offering identifiable customer benefit?

Can you use this approach to manage down your stock range?

Would it be reasonable to de-stock any line that had not sold a single unit in the last six months, or perhaps three months?

If you get a customer for the product next week, as you surely will in some cases, do you have an alternative to offer? Can your staff offer an explanation acceptable to the majority of your customers, which is still backed up by the offer to supply on special order if necessary?

Regardless of whether the future focus of pharmacy is on the retail offer or not, if you are to sell products to customers in any volume in the future I would recommend that you at least consider this approach to stock management.

direction you wish to move the business – healthcare, value, add-in's cave, medicines management – does your business put out a clearly identifiable message? Or rather, have you decided what you want your message to be?

Once you have established a system for stock management you

have achieved a consistency of data, and virtually future-proofed your ability to make rational stock decisions.

You can, for instance, explore the relationship between retail price and sales volume, and attendant profit levels and customer numbers.

But you can also begin to

understand the more subtle changes underlying the changing buying patterns of your customers – who may be significantly altering their purchases from you over a period of time.

A regular review of factors such as these is a major determinant of your ability to predict the future health of your business.

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Introducing the €uro

British pharmacists may have been celebrating the beginning of a new year, but for their German counterparts January 1 2002 was the beginning of a completely new era. **Nina Keller-Henman** follows one pharmacist as he prepares for the euro

New Year's Day 2002 was never going to be business as usual for German pharmacists as they switched from deutschmarks to the euro almost overnight.

Apart from the small starter packs the new currency had not been available until New Year's Eve.

"The euros are a lot heavier than the old deutschmarks," was the first thing Dr Hans Althoff, a pharmacist from Bendorf near Koblenz, noticed when he went for his special appointment with the bank on New Year's Eve.

Banks in Germany opened specially for their business customers, who had been asked to pre-order their euros.

Dr Althoff arrived at his pharmacy with 25kg of the new currency or 6,000 euros (£3,750).

One of his main concerns had been whether the pharmacy would have enough change in euros for the first few days.

"You don't want to have to run to the bank all the time, but at the same time we are supposed to give change in euros," he says.

The advice from ABDA, the German Pharmaceutical Association, had been to order 10 times the value of the normal daily float for each of the first three or four days.

Dr Althoff spent another four hours dealing with last minute preparations, such as running the software programme to update medicine prices and charges and adjusting the till drawers.

While the number of notes and coins is similar to before, their sizes are slightly different.

Dr Althoff was also keen to settle outstanding bills before the deadline, as well as endorse and price all prescriptions received before December 31, ahead of re-opening after the bank holidays.

He says this process would have been a lot more difficult after the euro's launch.

Everything else, such as upgrading the till software and credit/debit card machines, had already been dealt with over the previous five months.

The local prescription pricing authorities (Rechenzentren) will automatically switch to the euro for calculating and reimbursing prescriptions.

Dr Althoff had also made arrangements with the banks to transfer all direct debits and



Dr Hans Althoff: introducing the euro has gone very smoothly

standing orders into euros.

Lastly, all OTC medicines had already been priced in euros (as well as deutschmarks). Dr Althoff insisted that the official exchange rate (DM1.96 = €1) was used at all times.

So, Dr Althoff's Apotheke was ready for the euro-challenge.

When the pharmacy opened on January 2, a third till had been set up, to act as a "bureau de change". Customers were asked to exchange their deutschmarks for the new currency, so that the pharmacy's two regular tills only had to deal in euros.

"When you have to deal with two currencies at the same till, that's when it gets tricky. At the beginning you have to be extra careful, especially with the coins which are very similar in size," Dr Althoff explains.

He is, however, quite impressed with the improved security features, such as the raised print, the watermark and the shifting image on the foil strip on the front of the notes.

His son, Michael, was drafted in to oversee the exchange. To his surprise however, 20 per cent of all customers already had euros rather than deutschmarks in their wallets.

"Everything went really smoothly. The best way is definitely changing the money somewhere in the pharmacy first,"

says a relieved Dr Althoff.

There was only one slightly precarious moment, when a customer arrived with a DM500 note and wanted to exchange it to pay for her medication. The product in question cost more than DM400, but it could have meant giving out a large part of the pharmacy's euros.

An exception was made and she was allowed to pay with the DM500 note.

Dr Althoff admits that initially transactions may have taken a little longer than normal, particularly as some of his elderly customers needed things explained.

"One lady arrived and was very upset that she apparently had only been paid half her normal pension," he recalls, while another customer was sentimental for other reasons. For her, getting foreign currency had always represented the start of her holiday.

The euro certainly appears to have been well received in Germany, and according to Dr Althoff customers generally appear quite happy with the new currency.

One main challenge remains: how should he split up his €170 float between the various coins and notes?

But Dr Althoff anticipates that "within a fortnight it won't be an issue any more".

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4. Is he aware of the average stock holdings of retail chemists of similar size to yours? ☐ Yes ☐ No
5. Is he interested in your business? And the future of your business? ☐ Yes ☐ No
6. Is he imaginative and proactive? ☐ Yes ☐ No
7. Does he guide you on how to increase your profits? ☐ Yes ☐ No
8. Does he insist on and help you prepare quarterly management accounts so that you know what profit you are making? What tax you will have to pay and discuss your profit margins with you so that you can work towards improving these and therefore your net profit? ☐ Yes ☐ No
9. Does he have contacts in the pharmaceutical industry with stock takers, EPOS providers, shop fitters, purchase/sale agents, and specialist finance providers? ☐ Yes ☐ No
10. Is your top rate of tax 20%? If not, why not? Are you therefore paying 40%? ☐ Yes ☐ No
11. Has he reduced your tax liability by 50% annually by restructuring your business. Average tax savings would be about £8,000 p.a. ☐ Yes ☐ No
12. Has he suggested the possibility of setting up a personal or company pension scheme (SIPPS or SSASs)? This would enable you to get tax relief and allow you to purchase commercial properties in your pension fund, without having to pay capital gains tax ☐ Yes ☐ No
13. Can he set up employee benefit trusts, allowing you to obtain a full tax deduction for payments made e.g. payments of £50,000 can reduce your tax liability by about £10,000 ☐ Yes ☐ No
14. Can he set up an ERP? There are significant tax advantages of this scheme if set up correctly. ☐ Yes ☐ No
15. Has he set up offshore companies and trusts that allow you to accumulate vast amounts of wealth totally tax-free? ☐ Yes ☐ No
16. Does he help you plan to keep your wealth? Have you done your Inheritance tax planning? ☐ Yes ☐ No
17. Does he plan for the future sale of your business? The worst scenario should be a 10% tax liability, the best is no tax liability. ☐ Yes ☐ No
18. Do you receive advice throughout the year on how to reduce your tax bills? ☐ Yes ☐ No
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20. Does he prepare your accounts and tax returns on a timely basis? ☐ Yes ☐ No

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FREE LEGAL ADVICE



Chemist & Druggist's web site -
www.dotpharmacy.co.uk - has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service - dotLaw - is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to - pharmlaw@ubmint.com - along with their full name and the name of their pharmacy. The latter two details are for C&D's records only - pharmacists' identities will be kept anonymous when the answers are published.

All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

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Richard Forbes

Neil Topping, sales and marketing director for Phoenix Healthcare Distributions (PHD), and **Kenny Black**, operations director at L. Rowlands (retail), have been promoted to the UK board of Phoenix. Meanwhile the responsibility for group purchasing will transfer from David Cole (managing director of PHD and Phoenix chief executive designate) to **Stephan Lichtenheldt**, Phoenix's group operations director. **Richard Forbes**, a

light heavyweight boxer who last year captained the Scottish boxing team, has been appointed depot manager for Phoenix in Aberdeen. SkyePharma has appointed **Dr Paul Wotton** as global head of

business development.

Professor David Johns, former chairman of the Prescription Pricing Authority, has been appointed chairman of the Government's Genetic and Insurance Committee.

This week 1977

New premises for NPA

Twenty five years ago *C&D* announced the successful conclusion of the National Pharmaceutical Association's search for a new property. It had purchased "Donnington House", 40-42 St Peters Street, St Albans for £285,000.

The former Metropolitan College was described as "one of the most impressive buildings in the centre of St Albans" but there was much refurbishment planned for the future Mallinson House before the NPA could take up residence.



In 1977, computerised repeat prescribing was being trialed in a surgery in Devon. The big news was that the system could "automatically print out repeat prescriptions onto NHS forms ready for the doctor's signature". Apparently, the doctors were happy because statistics about prescribing were automatically maintained and even pharmacists welcomed the forms because they were legible. That was until the printer went off-line, presumably.

In the same issue there was a report on the debate about the safety of vaccines in children, this time the whooping cough vaccine. *Which?*, published by the Consumer's Association in January 1977, recommended that parents should not be put off having their children vaccinated against other diseases because of possible risks associated with the whooping cough vaccine. Plus ça change....

Nicorette yacht in twister scare



Nicorette and her crew face the billows

While Boxing Day passed in a fug of new jumpers, mixed nuts and cold turkey for most of us the crew

of the Nicorette yacht became involuntary storm chasers.

The yacht, competing in the Sydney to Hobart leg of the Volvo Ocean Race, was hit by a waterspout which showered the yacht with hailstones the size of golf balls, shredding its new mainsail.

Skipper Ludde Ingvall told the waiting media in Hobart he had feared for his life. "It was the most unbelievable thing I have ever seen," he said.

The yacht, a favourite to win that section of the race, eventually crossed the line in second position.

For more information:

www.sailing.nicorette.com.au

Germany's own "president's flat" affair

The German Pharmaceutical Association (ABDA) is embroiled in its very own "president's flat" controversy over its decision to buy a DM 47 million (£14.9m) palace in the heart of Berlin as its headquarters.

While the decision to relocate from Frankfurt to Berlin is largely undisputed, questions have been raised about the image such a grand building will convey.

Grassroots pharmacists also asked why the proposal was not put to members at the association's annual conference in Munich.

ABDA maintained that no other suitable building could be found and subsequently won approval from 73 per cent of local association delegates at an extraordinary general meeting.

Looking at it from a different angle though, 10 out of the 27 local associations voted against the purchase.

But the move will go ahead and ABDA will soon be based "a stone's throw from Government".

Bad spellers untie

We must apologise for a misspelling that appeared in the headline on page 11 of last week's issue, "DoH promises to cover pharmacists' ETP costs".

However, the spelling was brought on by an unfamiliarity with the word, so for all you pharmacists out there, may we offer our sincere apologies. Did we get the apostrophe in the write place?



Pharm has been helping assistants at Moss Pharmacy fight off colds and flu this winter by providing them with a supply of Redoxon Double Action Vitamin C. Amanda Williams and Eleanor Britton of the Moss Pharmacy in Yate, near Bristol, are pictured with Ian Crew, Roche's national product manager.



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- Participants will also learn about the relationship between good glycaemic control and HbA_{1c}, as well as the long term positive benefits of good glycaemic control.

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